

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 09/25/2012
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NAME OF PROVIDER OR SUPPLIER ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
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W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: September 17, 18, 20, 21, 24 and 25, 2012</p> <p>Facility number: 000972 Provider number: 15G458 AIM number: 100244840</p> <p>Surveyor: Brenda Nunan, RN, Public Health Nurse Surveyor III</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/1/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		

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

TITLE

(X6) DATE

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

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W0130	<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, the facility failed to ensure privacy of 1 additional client (#8) while he used the toilet.</p> <p>Findings include:</p> <p>During observations on 09/18/2012 at 6:10 a.m., the bathroom door was open 18 inches. Client #8 was seated on the toilet unclothed from the waist down. Direct Support Professional (DSP) #3 and DSP #8 walked past the open bathroom door and did not redirect the client to close the door. Client #3 walked past the bathroom while the door was open and client #8 was on the toilet.</p> <p>During an interview on 09/18/2012 at 7:55 a.m., DSP #3 stated, "[Client #8] had to use the bathroom when he was getting a breathing treatment so I left the door open to hear when the treatment finished."</p> <p>During an interview on 09/18/2012 at 8:40 a.m., Team Leader (TL) #1 indicated the bathroom door should have been closed while client #8 was using the</p>	W0130	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</i></p> <p>This practice is outside the expectations and practice standards for St. Vincent New Hope. Leadership staff reviewed findings and standards of conduct. Facility staff reviewed findings and expectations for privacy and dignity. Each facility staff completed a competency quiz regarding privacy and dignity scenarios.</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 resident dignity and privacy was addressed in training and the competency quizzes.</p> <p><i>What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur</i></p> <p>Facility nurse retrained staff on nebulizer treatment procedures in order to complete that task outside of the restroom, thereby eliminating the need to keep that door open.</p> <p><i>How the corrective action will be monitored to ensure the deficient</i></p>	10/12/2012			

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	toilet. 9-3-2(a)		<i>practice will not recur; what quality assurance program will be put into place.</i> Group Home Manager and Team Leader are routinely in the home and will monitor staff interactions for privacy and dignity. Group Home Team Leader will be in the home weekly to do a meal observation, enabling her to also monitor this issue has been resolved.		

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W0149	<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, the facility failed to implement their policy and procedures to thoroughly investigate allegations of abuse/neglect/injury of unknown origin for 9 of 21 incidents reviewed for allegations of abuse/neglect/injury of unknown origin for 2 of 4 sampled clients (clients #1 and #2) and 1 additional client (client #5).</p> <p>Findings include:</p> <p>The facility's reportable incident reports and investigations were reviewed on 09/17/2012 at 11:53 a.m.</p> <p>1. An Indiana Division of Disability and Rehabilitation Services incident report, dated 03/14/2012 at 8:00 p.m. indicated, "...During PM shower on 3/14 (2012) staff went to complete a body check and noted bruising on left arm. Individual (client #5) could not identify how it happened...."</p> <p>An undated Investigation Summary indicated, "...[Direct Support Professional (DSP) #4] stated that (client #2) did pull @ (at) [client #5's] shirt trying to keep her from going out the door...." The</p>	W0149	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. All investigations have been reviewed and completed. 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. Survey sample was inclusive of all relevant investigations. All other individuals who would have been affected were corrected with above review of investigations. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur</i></p> <p>Group Home Director reviewed the investigation form used and corrected problematic areas that had been confusing or overlooked. Form was reviewed with all leadership staff, particularly addressing finalization of investigation and timeliness. <i>How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place.</i> Director will maintain a file in which open investigations will be followed from initiation to completion. St. Vincent New Hope Quality</p>	10/12/2012	

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	<p>Investigation Summary did not indicate whether the facility determined the cause of the injury of unknown origin.</p> <p>2. An Indiana Division of Disability and Rehabilitation Services incident report, dated 05/04/2012 at 8:45 a.m., indicated, "...[Client #5] & (and) housemate (client #2) was (sic) getting on the van to be transported to Day program. [Client #5 set (sic) in a seat that another housemate usually sets (sic) in. Housemate (client #2) became upset with [client #5], yelling @ [client #5] telling her to get up. Housemate (client #2) hit [client #5] in the upper left thigh...."</p> <p>An Investigation Summary, dated 05/05/2012, did not indicate whether the facility substantiated or unsubstantiated the client abuse and did not indicate a recommendation for corrective action.</p> <p>3. An Indiana Division of Disability and Rehabilitation Services incident report, dated 06/12/2012 at 7:00 p.m., indicated, "...[Client #5] was scratched by peer (client #2) on left wrist...Suspected abused (sic) committee will convene and investigation will take place...."</p> <p>An Investigation Summary, dated 6/18/2012, did not indicate whether the facility substantiated or unsubstantiated</p>		<p>Assurance Department will also adjust tracking format that is used to include incident report initiation, duration, close date, and documentation received. This tracking will include all reportable incidents as well as investigations. This report will also now be generated weekly rather than monthly as previously done. GH Director will review tracking weekly to ensure all investigations have been finalized and completed as required.</p>				

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	<p>the allegation of client abuse and did not indicate a recommendation for corrective action.</p> <p>4. An Indiana Division of Disability and Rehabilitation Services incident report, dated 06/21/2012 at 8:20 p.m., indicated client #2 hit client #5 in the head. No injuries were reported.</p> <p>An undated Investigation Summary did not indicate whether the facility substantiated or unsubstantiated the allegation of client abuse and did not indicate a recommendation for corrective action.</p> <p>5. An Indiana Division of Disability and Rehabilitation Services incident report, dated 07/15/2012 at 8:00 p.m., indicated, "...[Client #2] started yelling @ (at) female housemate for unknown reason...Housemate slapped [client #2] in the upper arm and spit @ her...A 3rd housemate [client #5] saw the argument and came and smacked [client #2]...."</p> <p>An undated Investigation Summary did not indicate whether the facility substantiated or unsubstantiated the allegation of client abuse.</p> <p>6. An Indiana Division of Disability and Rehabilitation Services incident report,</p>						

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	<p>dated 08/02/2012 at 9:00 p.m., indicated, "...[Client #2] was setting (sic) on the couch with staff when housemate approached...Housemate (client #1) began shaking her finger @ [client #2]. [Client #2] got up from the couch and grabbed housemates (sic) hair...."</p> <p>An undated Investigation Summary did not indicate whether the facility substantiated or unsubstantiated client abuse and did not indicate recommendations for corrective action.</p> <p>7. An Indiana Division of Disability and Rehabilitation Services incident report, dated 08/07/2012 at 7:30 p.m., indicated, "...[Client #1] ran after housemate (client #2), spitting and pointing her finger. [Client #1] grabbed housemate (sic) chest and pulled her to her. [Client #1] pulled housemate (sic) hair the spit and grabbed housemate...."</p> <p>An Investigation Summary, dated 08/10/2012, did not indicate whether the facility substantiated or unsubstantiated client abuse and did not indicate a recommendation for corrective action.</p> <p>8. An Indiana Division of Disability and Rehabilitation Services incident report, dated 08/08/2012 at 5:30 p.m., indicated, "...[Client #1] came into the kitchen while</p>				

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	<p>another housemate (client #2) was there. They started to argue...they both started to pull each other's hair. The other housemate (client #2) scratched [client #1]...."</p> <p>An Investigation Summary, dated 08/08/2012, did not indicate whether the facility substantiated or unsubstantiated client abuse and did not indicate a recommendation for corrective action.</p> <p>9. An Indiana Division of Disability and Rehabilitation Services incident report, dated 08/09/2012 at 6:15 p.m., indicated, "...[Client #5] was wiping (sic) off the table after dinner when a female housemate (client #2) started making gestures @ [client #5]...Housemate became very angry and pushed [client #5]. [Client #5] fell and hit her head on the table. [Client #5] received a laceration on the top of her head...."</p> <p>An undated Investigation Summary did not indicate whether the facility substantiated or unsubstantiated client abuse and did not indicate recommendations for corrective action.</p> <p>A July 2012 policy, titled "Suspected Abuse" was reviewed on 09/18/2012 at 11:20 a.m. The policy indicated, "...SVNH (St. Vincent New Hope) will</p>						

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	<p>not condone abuse or violation of individual rights by anyone serving the individual...In the event there is an incident of suspected abuse, SVNH will comply will all applicable laws, statutes, and/or regulations with respect to reporting to authorities, investigation and warranted follow-up action to assure resolution...."</p> <p>During an interview on 09/20/2012 at 2:00 p.m., Team Leader (TL) #1 indicated client #2's Interdisciplinary Team (IDT) met following incidents of client to client aggression to formulate plans to decrease peer to peer aggression. TL #1 indicated counseling sessions were increased from monthly to weekly and alternate schedules were formulated for client #2 to minimize opportunities for unsupervised interactions with peers. TL #1 indicated the IDT met with client #2's guardian to discuss alternative living arrangements. TL #1 stated, "I did not fill out the new (investigation) forms correctly." TL #1 indicated her investigations did not indicate results/summaries of the investigations.</p> <p>9-3-2(a)</p>				

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W0154	<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 interview and record review, the facility failed to thoroughly investigate allegations of abuse/neglect/injury of unknown origin for 9 of 21 incidents reviewed for allegations of abuse/neglect/injury of unknown origin for 2 of 4 sampled clients (clients #1 and #2) and 1 additional client (client #5).</p> <p>Findings include:</p> <p>The facility's reportable incident reports and investigations were reviewed on 09/17/2012 at 11:53 a.m.</p> <p>1. An Indiana Division of Disability and Rehabilitation Services incident report, dated 03/14/2012 at 8:00 p.m. indicated, "...During PM shower on 3/14(2012) staff went to complete a body check and noted bruising on left arm. Individual (client #5) could not identify how it happened...."</p> <p>An undated Investigation Summary indicated, "...[Direct Support Professional (DSP) #4] stated that (client #2) did pull @ (at) [client #5's] shirt trying to keep her from going out the door...." The Investigation Summary did not indicate whether the facility determined the cause</p>	W0154	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</i></p> <p>All investigations have been reviewed and completed.</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>Survey sample was inclusive of all relevant investigations. All other individuals who would have been affected were corrected with above review of investigations.</p> <p><i>What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur</i></p> <p>Group Home Director reviewed the investigation form used and corrected problematic areas that had been confusing or overlooked. Form was reviewed with all leadership staff, particularly addressing finalization of investigation and timeliness.</p> <p><i>How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place.</i></p> <p>Director will maintain a file in which</p>	10/12/2012			

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	<p>of the injury of unknown origin.</p> <p>2. An Indiana Division of Disability and Rehabilitation Services incident report, dated 05/04/2012 at 8:45 a.m., indicated, "...[Client #5] & (and) housemate (client #2) was (sic) getting on the van to be transported to Day program. [Client #5] set (sic) in a seat that another housemate usually sets (sic) in. Housemate (client #2) became upset with [client #5], yelling @ [client #5] telling her to get up. Housemate (client #2) hit [client #5] in the upper left thigh...."</p> <p>An Investigation Summary, dated 05/05/2012, did not indicate whether the facility substantiated or unsubstantiated the client abuse.</p> <p>3. An Indiana Division of Disability and Rehabilitation Services incident report, dated 06/12/2012 at 7:00 p.m., indicated, "...[Client #5] was scratched by peer (client #2) on left wrist...Suspected abused (sic) committee will convene and investigation will take place...."</p> <p>An Investigation Summary, dated 6/18/2012, did not indicate whether the facility substantiated or unsubstantiated the allegation of client abuse.</p> <p>4. An Indiana Division of Disability and</p>		<p>open investigations will be followed from initiation to completion. St. Vincent New Hope Quality Assurance Department will also adjust tracking format that is used to include incident report initiation, duration, close date, and documentation received. This tracking will include all reportable incidents as well as investigations. This report will also now be generated weekly rather than monthly as previously done. GH Director will review tracking weekly to ensure all investigations have been finalized and completed as required.</p>				

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	<p>Rehabilitation Services incident report, dated 06/21/2012 at 8:20 p.m., indicated client #2 hit client #5 in the head. No injuries were reported.</p> <p>An undated Investigation Summary did not indicate whether the facility substantiated or unsubstantiated the allegation of client abuse.</p> <p>5. An Indiana Division of Disability and Rehabilitation Services incident report, dated 07/15/2012 at 8:00 p.m., indicated, "...[Client #2] started yelling @ (at) female housemate for unknown reason...Housemate slapped [client #2] in the upper arm and spit @ her...A 3rd housemate [client #5] saw the argument and came and smacked [client #2]...."</p> <p>An undated Investigation Summary did not indicate whether the facility substantiated or unsubstantiated the allegation of client abuse.</p> <p>6. An Indiana Division of Disability and Rehabilitation Services incident report, dated 08/02/2012 at 9:00 p.m., indicated, "...[Client #2] was setting (sic) on the couch with staff when housemate approached...Housemate (client #1) began shaking her finger @ [client #2]. [Client #2] got up from the couch and grabbed housemates (sic) hair...."</p>			

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	<p>An undated Investigation Summary did not indicate whether the facility substantiated or unsubstantiated client abuse.</p> <p>7. An Indiana Division of Disability and Rehabilitation Services incident report, dated 08/07/2012 at 7:30 p.m., indicated, "...[Client #1] ran after housemate (client #2), spitting and pointing her finger. [Client #1] grabbed housemate (sic) chest and pulled her to her. [Client #1] pulled housemate (sic) hair the spit and grabbed housemate...."</p> <p>An Investigation Summary, dated 08/10/2012, did not indicate whether the facility substantiated or unsubstantiated client abuse.</p> <p>8. An Indiana Division of Disability and Rehabilitation Services incident report, dated 08/08/2012 at 5:30 p.m., indicated, "...[Client #1] came into the kitchen while another housemate (client #2) was there. They started to argue...they both started to pull each other's hair. The other housemate (client #2) scratched [client #1]...."</p> <p>An Investigation Summary, dated 08/08/2012, did not indicate whether the facility substantiated or unsubstantiated</p>				

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	<p>client abuse.</p> <p>9. An Indiana Division of Disability and Rehabilitation Services incident report, dated 08/09/2012 at 6:15 p.m., indicated, "...[Client #5] was wiping (sic) off the table after dinner when a female housemate (client #2) started making gestures @ [client #5]...Housemate became very angry and pushed [client #5]. [Client #5] fell and hit her head on the table. [Client #5] received a laceration on the top of her head...."</p> <p>An undated Investigation Summary did not indicate whether the facility substantiated or unsubstantiated client abuse.</p> <p>During an interview on 09/20/2012 at 2:00 p.m., Team Leader (TL) #1 indicated client #2's Interdisciplinary Team (IDT) met following incidents of client to client aggression to formulate plans to decrease peer to peer aggression. TL #1 indicated counseling sessions were increased from monthly to weekly and alternate schedules were formulated for client #2 to minimize opportunities for unsupervised interactions with peers. TL #1 indicated the IDT met with client #2's guardian to discuss alternative living arrangements. TL #1 stated, "I did not fill out the new (investigation) forms correctly." TL #1</p>						

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	<p>indicated her investigations did not indicate results/summaries of the investigations.</p> <p>9-3-2(a)</p>			

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W0156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on interview and record review, the facility failed to report results of investigations of allegations of abuse/neglect/injury of unknown origin to the administrator within 5 working days of the incident for 8 of 21 incidents reviewed for allegations of abuse/neglect/injury of unknown origin for 2 of 4 sampled clients (clients #1 and #2) and 1 additional client (client #5).</p> <p>Findings include:</p> <p>The facility's reportable incident reports and investigations were reviewed on 09/17/2012 at 11:53 a.m.</p> <p>1. An Indiana Division of Disability and Rehabilitation Services incident report, dated 03/14/2012 at 8:00 p.m. indicated, "...During PM shower on 3/14(2012) staff went to complete a body check and noted bruising on left arm. Individual (client #5) could not identify how it happened...."</p> <p>An undated Investigation Summary did not indicate whether the facility determined the cause of the injury of</p>	W0156	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</i></p> <p>All investigations have been reviewed and completed. <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>Survey sample was inclusive of all relevant investigations. All other individuals who would have been affected were corrected with above review of investigations. <i>What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur</i></p> <p>Group Home Director reviewed the Investigation form used and corrected problematic areas that had been confusing or overlooked. Form was reviewed with all leadership staff, particularly addressing finalization of investigation and timeliness. In addition, a specific signature line for administration review of the investigation was added. <i>How the corrective action will be monitored to ensure the deficient</i></p>	10/12/2012
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	<p>unknown origin and did not indicate the administrator was notified of the investigation results within 5 working days of the incident.</p> <p>2. An Indiana Division of Disability and Rehabilitation Services incident report, dated 06/12/2012 at 7:00 p.m., indicated, "...[Client #5] was scratched by peer on left wrist...Suspected abused (sic) committee will convene and investigation will take place...."</p> <p>An Investigation Summary, dated 6/18/2012, did not indicate whether the facility substantiated or unsubstantiated the allegation of client abuse. The Investigation Summary did not indicate the administrator was notified of the investigation results within 5 working days of the incident.</p> <p>3. An Indiana Division of Disability and Rehabilitation Services incident report, dated 06/21/2012 at 8:20 p.m., indicated client #2 hit client #5 in the head. No injuries were reported.</p> <p>An undated Investigation Summary did not indicate whether the facility substantiated or unsubstantiated the allegation of client abuse. The Investigation Summary did not indicate the administrator was notified of the</p>		<p><i>practice will not recur; what quality assurance program will be put into place.</i></p> <p>Director will maintain a file in which open investigations will be followed from initiation to completion. St. Vincent New Hope Quality Assurance Department will also adjust tracking format that is used to include incident report duration, close date, and documentation received. This tracking will include all reportable incidents as well as investigations. This report will also now be generated weekly rather than monthly as previously done. GH Director will review tracking weekly to ensure all investigations have been finalized and completed as required.</p>				

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	<p>investigation results within 5 working days of the incident.</p> <p>4. An Indiana Division of Disability and Rehabilitation Services incident report, dated 07/15/2012 at 8:00 p.m., indicated, "...[Client #2] started yelling @ (at) female housemate (client #1) for unknown reason...Housemate slapped [client #2] in the upper arm and spit @ her...A 3rd housemate [client #5] saw the argument and came and smacked [client #2]...."</p> <p>An undated Investigation Summary did not indicate whether the facility substantiated or unsubstantiated the allegation of client abuse. The Investigation Summary did not indicate the administrator was notified of the investigation results within 5 working days of the incident.</p> <p>5. An Indiana Division of Disability and Rehabilitation Services incident report, dated 08/02/2012 at 9:00 p.m., indicated, "...[Client #2] was setting (sic) on the couch with staff when housemate approached...Housemate (client #1) began shaking her finger @ [client #2]. [Client #2] got up from the couch and grabbed housemates (sic) hair...."</p> <p>An undated Investigation Summary did</p>			

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	<p>not indicate whether the facility substantiated or unsubstantiated client abuse. The Investigation Summary did not indicate the administrator was notified of the investigation results within 5 working days of the incident.</p> <p>6. An Indiana Division of Disability and Rehabilitation Services incident report, dated 08/07/2012 at 7:30 p.m., indicated, "...[Client #1] ran after housemate (client #2), spitting and pointing her finger. [Client #1] grabbed housemate (sic) chest and pulled her to her. [Client #1] pulled housemate (sic) hair the spit and grabbed housemate...."</p> <p>An Investigation Summary, dated 08/10/2012, did not indicate whether the facility substantiated or unsubstantiated client abuse. The Investigation Summary did not indicate the administrator was notified of the investigation within 5 working days of the incident.</p> <p>7. An Indiana Division of Disability and Rehabilitation Services incident report, dated 08/08/2012 at 5:30 p.m., indicated, "...[Client #1] came into the kitchen while another housemate (client #2) was there. They started to argue...they both started to pull each other's hair. The other housemate (client #2) scratched [client #1]...."</p>						

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	<p>An Investigation Summary, dated 08/08/2012, did not indicate whether the facility substantiated or unsubstantiated client abuse. The Investigation Summary did not indicate the administrator was notified of the investigation within 5 working days of the incident.</p> <p>8. An Indiana Division of Disability and Rehabilitation Services incident report, dated 08/09/2012 at 6:15 p.m., indicated, "...[Client #5] was wipeing (sic) off the table after dinner when a female housemate (client #2) started making gestures @ [client #5]...Housemate became very angry and pushed [client #5]. [Client #5] fell and hit her head on the table. [Client #5] received a laceration on the top of her head...."</p> <p>An undated Investigation Summary did not indicate whether the facility substantiated or unsubstantiated client abuse. The Investigation Summary did not indicate the administrator was notified of the investigation within 5 working days of the incident.</p> <p>During an interview on 09/20/2012 at 2:00 p.m., Team Leader (TL) #1 indicated client #2's Interdisciplinary Team (IDT) met following incidents of client to client aggression to formulate plans to decrease</p>						

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	<p>peer to peer aggression. TL #1 indicated counseling sessions were increased from monthly to weekly and alternate schedules were formulated for client #2 to minimize opportunities for unsupervised interactions with peers. TL #1 indicated the IDT met with client #2's guardian to discuss alternative living arrangements. TL #1 stated, "I did not fill out the new (investigation) forms correctly." TL #1 indicated her investigations did not indicate results/summaries of the investigations. TL #1 did not indicate if the administrator was notified of investigation results for allegations of abuse/neglect or injuries of unknown origin.</p> <p>9-3-2(a)</p>				

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W0268	<p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation and interview, the facility failed to protect and/or promote dignity by allowing a client to eat in the dining room without pants over his incontinence briefs for 1 additional client (client #8).</p> <p>Findings include:</p> <p>During observations on 09/18/2012 at 5:15 a.m., Direct Support Professional (DSP) #3 and DSP #7 were present in the dining room with clients #1, #4, #5, #7, and #8. Client #8 wore a tee shirt and incontinence briefs. DSP #3 and DSP #8 did not redirect client #8 to put clothing over his incontinence briefs.</p> <p>During an interview on 09/18/2012 at 7:55 a.m., DSP #7 stated "He is wearing a long shirt so it's okay (to be partially dressed)." DSP #7 indicated client #8 had a history of tearing his clothing.</p> <p>During an interview on 09/18/2012 at 8:40 a.m., Team Lead (TL) #1 indicated client #8 should have been redirected to wear pants at the dining table since housemates were female and a guest was present in the home.</p>	W0268	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</i></p> <p>This practice is outside the expectations and practice standards for St. Vincent New Hope. Leadership staff reviewed findings and standards of conduct. Facility staff reviewed findings and expectations for privacy and dignity. Each facility staff completed a competency quiz regarding privacy and dignity scenarios.</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 resident dignity and privacy was addressed in training and the competency quizzes.</p> <p><i>What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur</i></p> <p>Identified practices and expectations continue to uphold dignity, respect and privacy. On this occasion, staff varied from accepted practice and were coached and retrained on the expectations.</p> <p><i>How the corrective action will be monitored to ensure the deficient</i></p>	10/12/2012			

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	9-3-5(a)		<p><i>practice will not recur; what quality assurance program will be put into place.</i></p> <p>Manager is in the home at minimum weekly. Team Leader is in the home 3-5 times per week and will be conducting meal observations to address mealtime deficient practice by staff. At this time, she will also be able to observe and ensure privacy and dignity standards are corrected as well. Any further variance from expected standard of conduct will be addressed with further disciplinary action and training.</p>		

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W0323	<p>483.460(a)(3)(i) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on interview and record review, the facility failed to ensure annual physical examinations that included a minimum of vision and hearing evaluation for 1 of 4 sampled clients (client #4).</p> <p>Findings include:</p> <p>1. Client #4's record was reviewed on 09/18/2012 at 1:16 p.m. A "MEDICAL APPOINTMENT/NEW ORDER FORM," dated 11/05/2009, indicated, "Hearing evaluation testing completed to determine candidacy for HA's (hearing aids)...could not measure benefit (symbol for with) HA; therefore not rec (recommended) @ (at) this time...F/U (follow up) one yr (year)." The record did not indicate a follow up hearing evaluation had been completed.</p> <p>A physical examination completed on 07/26/2012 did not indicate annual hearing screening had been completed.</p> <p>During an interview on 09/20/2012 at 2:00 p.m., the facility nurse indicated the hearing evaluation had not been completed when recommended and</p>	W0323	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</i></p> <p>Appointment will be completed 10/23/12</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>Nurse consultant and Team Leader of home reviewed their comprehensive list of all current appointments. This was the only appointment noted to have been missed of all residents.</p> <p><i>What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur</i></p> <p>Monthly, the nurse consultant will forward all expected appointments to the Team Leader to schedule, including all labs.</p> <p>QMRP and Nurse Consultant will meet with Director weekly to follow up on all appointment, lab and outstanding medical issues.</p> <p><i>How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place.</i></p>	10/12/2012			

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	indicated a hearing evaluation was not completed with the annual physical. 9-3-6(a)		QMRP, Nurse Consultant and Director will meet weekly to review appointment and follow up status		

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W0331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview, the facility failed to ensure nursing services followed up on physician recommendations and failed to ensure facility staff were trained to meet the health needs for 3 of 4 sampled clients (clients #1, #2 and #4).</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 09/18/2012 at 12:35 p.m. A physician's recapitulation, dated 09/01/2012-09/30/2012, indicated, "... CBC (complete blood count), CMP (comprehensive metabolic panel), DILANTIN (anti-seizure medication) LEVEL EVERY 3 MONTHS...." The record indicated a CBC and CMP were completed 04/21/2012. The record did not indicate a Dilantin level was completed during the past year and did not indicate all recommended laboratory tests were completed at the frequency recommended by the physician.</p> <p>2. Client #2's record was reviewed on 09/20/2012 at 11:13 a.m. A "MEDICAL APPOINTMENT/NEW ORDER FORM," dated 03/23/2012, indicated, "...follow-up for R-worm (ringworm)..."</p>	W0331	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</i></p> <p>A specific skin/dermatitis protocol was developed for client. She has had physician indicate that she will have recurring dermatitis due to skin sensitivity and eczema. High Risk Plan was revised to include this information and needed guidelines for staff. Staff were trained on proper protocol and high risk plan strategies.</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 other individuals in the home were reviewed and no other individuals present skin dermatitis issues.</p> <p><i>What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur</i></p> <p>High Risk Plan developed. Staff will conduct daily body check and notify nurse of any changes.</p> <p><i>How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place.</i></p> <p>Nurse will review body checks and</p>	10/12/2012			

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	<p>A "MEDICAL APPOINTMENT/NEW ORDER FORM," dated 04/19/2012, indicated, "...Tinea Corporis (ringworm)...."</p> <p>A "MEDICAL APPOINTMENT/NEW ORDER FORM," dated 05/08/2012, indicated, "...follow-up ringworm...no further treatment needed for rash...."</p> <p>A "MEDICAL APPOINTMENT/NEW ORDER FORM," dated 06/7/2012, indicated, "...F/U (follow up) from visit on 5/16/(2012) rash...Recommend derm (dermatology) if no improvement 10-14 days...." The record did not indicate a medical appointment form from 05/16/2012.</p> <p>A dermatologist "MEDICAL APPOINTMENT/NEW ORDER FORM," dated 07/20/2012, indicated "...T. Corporis (ringworm)...."</p> <p>A "MEDICAL APPOINTMENT/NEW ORDER FORM," dated 08/03/2012, indicated Follow up of Ringworm..."</p> <p>3. Client #4's record was reviewed on 09/18/2012 at 1:16 p.m. A "MEDICAL APPOINTMENT/NEW ORDER FORM,"dated 11/05/2009, indicated, "Hearing evaluation testing completed to</p>		monitor skin on a monthly or as needed basis.		

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	<p>determine candidacy for HA's (hearing aids)...could not measure benefit (symbol for with) HA; therefore not rec (recommended) @ (at) this time...F/U (follow up) one yr (year). The record did not indicate a follow up hearing evaluation had been completed.</p> <p>A physical examination completed on 07/26/2012 did not indicate annual hearing screening had been completed.</p> <p>During an interview on 09/20/2012 at 2:00 p.m., the facility nurse indicated client #1 did not have laboratory tests as recommended by the physician. The facility nurse indicated client #4 did not have a follow up hearing evaluation as recommended by the audiologist. The facility nurse indicated she had not provided staff training in regard to care of the individual with ringworm and precautions to prevent spread of ringworm.</p> <p>9-3-6(a)</p>				

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NAME OF PROVIDER OR SUPPLIER ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
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W0391	<p>483.460(m)(2)(ii) DRUG LABELING</p> <p>The facility must remove from use drug containers with worn, illegible, or missing labels.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the label on a medication container was legible for 1 of 26 medications for 1 additional client (client #8).</p> <p>Findings include:</p> <p>During observations on 09/17/2012 at 4:00 p.m., Direct Support Professional (DSP) #10 administered eye drops to client #8 from a container with a label where the printed instructions had completely faded from the label.</p> <p>The September 2012 Medication Administration Record was reviewed on 09/18/2012 at 8:30 a.m. The record indicated, "BLINK TEARS DPO (drops) 0.25% INSTILL 1 DROP INTO EACH EYE 3 TIMES DAILY...."</p> <p>The Physician's Orders, dated 09/01/2012-09/30/2012, indicated, "BLINK TEARS DPO (drops) 0.25% INSTILL 1 DROP INTO EACH EYE 3 TIMES DAILY...."</p> <p>During an interview on 09/17/2012 at 4:05 p.m., DSP #10 indicated he was not</p>	W0391	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</i></p> <p>This medication was replaced 9/26/12.</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 other medications and labels were reviewed on 9/27/12. All labels are clearly marked and legible. <i>What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur</i></p> <p>Team Leader conducts a weekly pill count in of all medications, liquids and biologicals. Within that pill count process, she will also check the med labels to ensure nothing has worn or changed their legibility though out the week. That will be documented on the pill count sheet weekly.</p> <p><i>How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place.</i></p> <p>TL will submit pill count to Manager monthly.</p>	10/12/2012

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	<p>able to read the medication label. He stated, "I read the MAR (Medication Administration Record)," when asked about the number of drops administered and whether the drops were administered in one or both eyes.</p> <p>During an interview on 09/18/2012 at 8:40 a.m., Team Lead (TL) #1 indicated the medication label should have been legible.</p> <p>9-3-6(a)</p>			

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NAME OF PROVIDER OR SUPPLIER ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208			
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W0455	<p>483.470(l)(1) INFECTION CONTROL</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>Based on observation, record review and interview, the facility failed to ensure infection control/prevention for 1 of 4 sampled clients (client #2) and failed to ensure medications were handled in a sanitary manner for 1 additional client (client #8).</p> <p>Findings include:</p> <p>1. During observations on 09/18/2012 at 6:20 a.m., client #8 was seated on the toilet while receiving a nebulizer (device to deliver medication in a mist form) respiratory treatment. Client #8 touched the toilet seat, then touched his nebulizer mouth piece/mask while the medication was being administered.</p> <p>Client #8's record was reviewed on 09/21/2012 at 10:30 a.m.. The Physician's Recapitulation, dated, 09/01/2012-09/30/2012, indicated, "...ALBUTEROL(used to prevent wheezing) NEB (nebulizer) 0.083% INHALE 1 VIAL VIA NEBULIZER W/ (WITH) IPRATROPIUM (used to prevent wheezing) 3 TIMES DAILY AS NEEDED...."</p>	W0455	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</i></p> <p>Nebulizer procedure was developed for client to identify proper procedure, clean techniques and infection control direction. All staff were trained on nebulizer procedure as well as sanitary medication administration.</p> <p>A specific skin/dermatitis protocol was developed for client. She has had physician indicate that she will have recurring dermatitis due to skin sensitivity and eczema. High Risk Plan was revised to include this information and needed guidelines for staff. Staff were trained on proper protocol and high risk plan strategies.</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 other client treatments were reviewed and have appropriate protocols and training.</p> <p><i>What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur</i></p> <p>Nurse consultant will continue medication and treatment</p>	10/12/2012			

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	<p>2. Client #2's record was reviewed on 09/20/2012 at 11:13 a.m. A "MEDICAL APPOINTMENT/NEW ORDER FORM," dated 03/23/2012, indicated, "...follow-up for R-worm (ringworm)...."</p> <p>A "MEDICAL APPOINTMENT/NEW ORDER FORM," dated 04/19/2012, indicated, "...Tinea Corporis (ringworm)...."</p> <p>A "MEDICAL APPOINTMENT/NEW ORDER FORM," dated 05/08/2012, indicated, "...follow-up ringworm...no further treatment needed for rash...."</p> <p>A "MEDICAL APPOINTMENT/NEW ORDER FORM," dated 06/7/2012, indicated, "...F/U (follow up) from visit on 5/16/(2012) rash...Recommend derm (dermatology) if no improvement 10-14 days...." The record did not indicate a medical appointment form from 05/16/2012.</p> <p>A dermatologist "MEDICAL APPOINTMENT/NEW ORDER FORM," dated 07/20/2012, indicated "...T. Corporis (ringworm)...."</p> <p>A "MEDICAL APPOINTMENT/NEW ORDER FORM," dated 08/03/2012, indicated Follow up of Ringworm..."</p>		<p>observation to ensure techniques are being utilized appropriately and protocols are being followed. High Risk Plan developed. Staff will conduct daily body check and notify nurse of any changes to skin</p> <p><i>How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place.</i></p> <p>Nurse Consultant, Manager/QDDP and Director will meet weekly to review appts, labs, medical concerns, observations. Nurse will review body checks and monitor skin on a monthly or as needed basis.</p>				

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NAME OF PROVIDER OR SUPPLIER ST VINCENT NEW HOPE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208		
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	<p>During an interview on 09/18/2012 at 7:55 a.m., Direct Support Professional (DSP) #7 stated, "[Client #8] had to use the bathroom at the same time he needed his breathing treatment." DSP #7 stated, "The door was left open so we could hear when the treatment was done."</p> <p>During an interview on 09/20/2012 at 2:00 p.m., the facility nurse indicated client #8 should not have received a nebulizer delivered medication while seated on the toilet. The facility nurse indicated she had not trained staff in regard to techniques such as keeping client #2's skin clean and dry, washing sheets and night clothes daily, and sanitizing contaminated surfaces to prevent spread of ringworm.</p> <p>9-3-7(a)</p>				

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W0460	<p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>Based on observation, interview and record review, the facility failed to ensure the planned menus were followed for breakfast and/or failed to ensure substitution/selective menus were followed to ensure clients received a balanced meal/diet for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 3 additional clients (#5, #6, and #7).</p> <p>Findings include:</p> <p>During observations on 09/18/2012 at 5:15 a.m. clients #1, #4, #5, #6, and #7 each had 2 waffles with margarine and syrup, apple juice and milk. Direct Support Professional (DSP) #3 and #7 did not offer/provide whole grain cereal or a suitable substitution.</p> <p>During observations on 09/18/2012 at 5:45 a.m., client #3 had 2 waffles with margarine and syrup, apple juice and milk. DSP #3 and #7 did not offer/provide whole grain cereal or a suitable substitution.</p> <p>During observations on 09/18/2012 at 8:10 a.m., client #2 had whole grain cereal with milk and 1 slice of french</p>	W0460	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</i></p> <p>All staff were retrained on dining plans, meal prep and dining goals for all individuals. Each individual has a specific meal prep and eating goal toward independence.</p> <p>Staff were retrained on menus and food substitutions. A specific food substitution form was developed to better document the choices made.</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. Each person's plans and goals were reviewed. Staff expectation regarding food preparation, active treatment and dining was reviewed.</p> <p><i>What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur</i></p> <p>Team Leader will conduct monthly meal observation, the first being with this particular morning meal timeframe to address any further issues related to accomplishing this expectation.</p> <p><i>How the corrective action will be</i></p>	10/12/2012

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	<p>toast with margarine. Client #2 indicated the facility was out of juice.</p> <p>The "SPRING/SUMMER MENU," dated week 1, was reviewed on 09/18/2012 at 11:20 a.m. The menu indicated, "...3/4 c (cup) Apple juice, 2 sm (small) Pancakes, 2 oz (ounces) Sugar Free Syrup, 1 tsp (teaspoon) Margarine, 1/2 c Whole Grain ck (cooked) Cereal, 1 c water, Coffee/Tea if desired, 1 c SK (skim) or 1/2 % (percent) Milk...."</p> <p>During an interview on 09/18/2012 at 8:10 a.m., TL #1 stated, "I don't know what happened to all the juice. We had 2 large containers in the refrigerator last night." TL #1 indicated DSP #3 and #7 should have offered/provided all menu items or an appropriate substitution.</p> <p>9-3-8(a)</p>		<p><i>monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place.</i></p> <p>Team Leader will submit meal observations to QMRP monthly for review.</p>		

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W0488	<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 and interview, the facility failed to encourage clients to participate in dining procedures to the extent they were capable for 2 of 4 sampled clients (clients #2 and #4).</p> <p>Findings include:</p> <p>During observations on 09/18/2012 at 5:15 a.m., Direct Support Professional (DSP) #4 used a rocker knife to cut client #4's waffles. Client #4 was not encouraged to cut her own waffles.</p> <p>During observation on 09/18/2012 at 8:10 a.m., client #2 told DSP #1 what food items to pack in her lunch bag while she ate her breakfast. DSP #1 placed the menu items in client #2's lunch bag.</p> <p>During an interview on 09/18/2012 at 8:10 a.m., Team Lead (TL) #1 stated, "[Client #2] used to pack her lunches in the evening." TL #1 indicated client #2 frequently changed her mind about wanting the items packed the previous evening. TL #1 indicated client #2 was capable of packing her lunch. She stated, "Staff sometimes pack [client #2's] lunches for the sake of time." TL #1</p>	W0488	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</i></p> <p>All staff were retrained on dining plans, meal prep and dining goals for all individuals. Each individual has a specific meal prep and eating goal toward independence.</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. Each person's plans and goals were reviewed. Staff expectation regarding food preparation, active treatment and dining was reviewed.</p> <p><i>What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur</i></p> <p>Team Leader will conduct monthly meal observation, the first being with this particular morning meal timeframe to address any further issues related to accomplishing this expectation.</p> <p><i>How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place.</i></p>	10/12/2012			

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	<p>indicated client #4 was capable of cutting with the rocker knife. TL #1 indicated DSP #7 should have encouraged client #4 to use the rocker knife.</p> <p>9-3-8(a)</p>		<p>Team Leader will submit meal observations to QMRP monthly for review.</p>	