STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G487	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT NEW HOPE INC	4822 ALAMEDA ST INDIANAPOLIS, IN 46208

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W000000	This visit was for investigation of complaint #IN00131262. Complaint #IN00131262: Substantiated. Federal and state deficiency related to the allegation is cited at W149. Dates of Survey: June 25, 26 and 27, 2013. Facility Number: 001001 Provider Number: 15G487 AIMS Number: 100245000 Surveyor: Claudia Ramirez, RN This deficiency also reflects state findings in accordance with 460 IAC 9. Quality Review completed 7/3/13 by Ruth Shackelford, QIDP.	W000000		

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

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

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W000149	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 record review and interview for 3 of 5 BDDS (Bureau of Developmental Disabilities Services) reports, the facility neglected to implement the facility's policy and procedure to prevent punishment to client A for his behaviors and neglected to prevent client to client abuse which resulted in injury to clients A and F. Findings include: On 06/25/13 at 2:31 PM a record review of the BDDS reports was completed and included the following: 06/18/13: A BDDS report submitted on 06/19/13 for an incident dated 06/18/13 at 1:12 PM indicated, "It was reported to this writer that a staff member witnessed [client A] being pulled across the floor by another staff person. He was allegedly pulled out of the room he was in and into the hallway. The Director was notified of this incident and the staff person was suspended and escorted from the building pending further investigation. Three staff members were interviewed about the incident. Staff reported that [client A]	W000149	*What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.* 6/25/13 incident: St. Vincent New Hope engaged with the day program provider to ensure staff were retrained on abuse and neglect as well as the behavior plan techniques for client A. St. Vincent New Hope conducted an investigation including the actions and response of the day program provider. All responses and procedures were found to be appropriate and coincide with St. Vincent New Hope policy and procedure and regulatory requirements. Day program staff elected to leave employment during their investigation. 6/18/13 incident: Behavior Consultant met with Client E and continues to see him regularly to work toward coping skills. Staff have been trained on his behavior plan and responded appropriately to incident. Client E family contacted to assist in supporting him with appropriate choices. 3/21/13 incident: Team met to discuss needed interventions to this incident. At that time, it was deemed necessary to keep the two gentlemen away from each other and discourage Client C from	07/15/2013

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	entered the kitchen area and was verbally redirected to go back to another room, when he did not leave the room the staff person approached him and put a hand on his shoulder and tried to redirect him out of the room. At this point [client A] sat down on the floor. It was reported that the staff person then took [client A's] legs and pulled him from the room into the hallway. The staff then left [client A] in the hall and closed the door to the kitchen. Staff person was interviewed the following morning and during the interview process choose (sic) to resign. Her resignation was accepted. All staff will review [client A's] Individual Support Plan (ISP) to ensure that everyone knows how to appropriately redirect [client A]." 04/28/13: A BDDS report submitted on 04/28/13 for an incident dated 04/28/13 at 7:30 AM indicated, "On 04/28/13, at 730am, (sic) Direct Support Specialist, [staff #1], contacted writer to inform her that [client E] had pushed housemate (client A) causing him to fall and hit his head. Writer went to the site to assist [staff #1] and found [client E] watching television in the living room. He was not agitated or upset. Writer attempted to discuss incident with [client E] but he would not discuss it. He walked back and forth through the dining room and stated		entering Client F's private bedroom at any time. There is no egress and there is no other reason he would need to be entering this area. They reside in two separate areas of the home so the bedroom is the only area in which they are possibly unobserved. This solution has proven effective at this point. There have been no other altercations between these two gentlemen. *How will other residents be identified as having the potential to be affected by the same deficient practice and what corrective action will be taken.* All residents have the potential to be affected. All staff were retrained on behavior plan techniques and abuse/neglect policy and procedure. No other incidents have been reported regarding this staff or any other for the other residents of the facility. The gentlemen residing in this home are placed in rooms based on physical risk as well as need to observe them more closely. This home allows the common areas to be a natural divider between people who may not socialize well together without support. *What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur? How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance*	

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	that housemate needed to leave. [Client A] had an approx[imately] 1 inch cut above the right eyebrow and skinned his right knee. On call Nurse was notified and [client A] was sent to the ER (Emergency Room)...[Client A] was seen by Emergency Department and received stitches...." 03/21/13: A BDDS report submitted on 03/22/13 for an incident dated 03/21/13 at 4:00 PM indicated, "Staff observed [client F] coming from his room and his nose was bleeding. [Client F] told staff the (sic) a housemate (client C) had come into his room and bit him on his nose. Staff applied first aid and notified Team Leader and Nurse. Nurse observed [client F] and had staff take him to immediate care....When questioned, [Client C] admitted to biting he (sic) nose of his housemate (client A). [Client C] said he bit him because he was getting on his nerves...." On 06/25/13 at 3:00 PM, a review of the facility's 07/2012 Policy on Suspected Abuse indicated, "St Vincent New Hope (SVNH) will not condone abuse or violation of individual rights by anyone, including, but not limited to associates, consultants or volunteers, staff or other agencies serving the individual...SVNH will comply with all applicable laws,		*program will be put into place.* Director is copied and notified on all incidents within 24 hours. Reportable incidents are tracked by St. Vincent New Hope Quality Assurance. Director receives a weekly copy of this spreadsheet for oversight purposes. In addition, QDDP and Team Leader will maintain routine contact with day program staff to oversee appropriate behavior plan intervention. Contact will be maintained at minimum monthly or upon any future incident of concern. Behavior consultant, QDDP, TL continue to meet monthly regarding treatment plan for all individuals in this home. The team also determines any emergent needs as a concern may arise. St. Vincent New Hope will continue to follow policy and procedure for abuse, neglect and exploitation should further incidents occur.	

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	statutes, and/or regulations with respect to reporting to authorities, investigation and warranted follow-up action to assure resolution...Indiana public law protects endangered adults...from abuse, battery, neglect and exploitation or mistreatment. An endangered adult is any individual who is 18 years of age or older who: is incapable of managing his property or caring for himself or both by reason of insanity, mental illness, mental retardation...of either managing his property or caring for himself or both; is harmed or threatened with harm as a result of neglect, battery, or exploitation of the individual's personal services or property...." An interview was conducted on 06/26/13 at 12:30 PM with the Director of Group Homes (DGH). The DGH indicated the staff failed to follow the agency's policy/procedure on abuse/neglect when she pulled on client A's legs to get him from the room into the hallway and he did not want to go. The DGH also indicated the agency's policy prohibits client to client abuse and the agency failed to keep clients A and F safe and free from abuse causing injury by clients C and E. This federal tag relates to complaint #IN00131262.			

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