

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G716	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/23/2014
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NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8521 CROWN POINT RD INDIANAPOLIS, IN 46278
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W000000	<p>This visit was for the investigation of complaint #IN00159834.</p> <p>Complaint #IN00159834: Substantiated, federal and state deficiencies related to the allegations are cited at: W102, W104, W122, W149, W153, W154, W157 and W331.</p> <p>Dates of Survey: 12/18/14 and 12/23/14.</p> <p>Facility Number: 004061 Provider Number: 15G716 AIMS Number: 200483530</p> <p>Surveyor: Keith Briner, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed December 30, 2014 by Dotty Walton, QIDP.</p>	W000000		
W000102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on record review and interview,</p>	W000102	What corrective action will be	01/22/2015

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>the facility failed to meet the Condition of Participation: Governing Body for 2 of 2 sampled clients (A and B). The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent neglect of client A during bathing/showering, to ensure an allegation of staff mistreatment regarding client B was immediately reported to the TL (Team Leader), to thoroughly investigate an IOU (Injury of Unknown Origin) regarding client A and an allegation of staff mistreatment regarding client B, to develop and implement safeguards to prevent further incidents of injury of client A during showering and address staff's failure to immediately report an allegation of staff mistreatment of client B and to ensure the facility's nursing services met the health needs of client A.</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the Condition of Participation: Client Protections was met for 2 of 2 sampled clients (A and B). The facility failed to implement its policy and procedures to prevent neglect of client A during</p>		<p><i>accomplished for these residents found to have been affected by the deficient practice? How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?</i></p> <p>High Risk Plan for Client A was reviewed and revised to include all safeguards and instruction for showering and bathing and further fall/injury prevention.</p> <p>High Risk Plan for all other individuals will be reviewed.</p> <p>Staff will be retrained on all fall risk plans and morning routine expectations at mandatory staff training meeting, January 13, 2015.</p> <p>Upon discovery of staff #2's admission to breach in procedure during the survey process, Director and Manager reopened the 11/19/14 investigation. Manager suspended staff #2 immediately upon discovery of breach in procedure. Manager interviewed all other staff that day to ensure all others were following the established procedure and risk plan for Client A. Staff #2 met with Director and Manager on 12/29/14 after 3 day disciplinary suspension to review all expectations surrounding following established safety procedures. Staff #2 was given specific direction on the</p>	

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	<p>bathing/showering, to ensure an allegation of staff mistreatment regarding client B was immediately reported to the TL, to thoroughly investigate an IOU regarding client A and an allegation of staff mistreatment regarding client B, to develop and implement safeguards to prevent further incidents of injury of client A during showering and address staff's failure to immediately report an allegation of staff mistreatment of client B. Please see W122.</p> <p>This federal tag relates to complaint #IN00159834.</p> <p>9-3-1(a)</p>		<p>morning routine and was observed 12/30/14 upon return to work on 12/30/14 to be completing this accurately.</p> <p>Direct observation of client personal care will continue by QIDP and TL to ensure compliance. Unannounced weekly visits will occur for one month following the above mentioned observation.</p> <p>New Hope of Indiana Group Home leadership staff will be retrained on the investigation process, specifically emphasizing the requirement to interview at minimum all personnel involved in the last 24 hours and include any recommendation for deficiency or incompetence in the investigation summary.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure these deficient practices do not recur? How the corrective actions will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place?</i></p> <p>Nursing staff will review requirements and noted deficiencies for all risk plans.</p> <p>Director will review all current risk plans and any future risk plans prior to implementation.</p> <p>Manager/QIDP and Team Leader will</p>		

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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 record review and interview for 2 of 2 sampled clients (A and B), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent neglect of client A during bathing/showering, to ensure an allegation of staff mistreatment regarding</p>	W000104	<p>develop a specific morning routine schedule. Schedule will ensure that staffing and tasks are appropriately timed for client safety.</p> <p>Quality Assurance will review all investigation requirements and noted deficiencies for investigations.</p> <p>Director and Quality Assurance will continue to review all investigations for thorough completion, specifically noting all possible informants are interviewed and any deficiencies are noted in the recommendation section. Director will create a review document to assist in checking that all elements of a thorough investigation are completed. Document will be signed by Director and included in all investigation folders.</p> <p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice? How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?</i></p>	01/22/2015

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	<p>client B was immediately reported to the TL (Team Leader), to thoroughly investigate an IOU (Injury of Unknown Origin) regarding client A and an allegation of staff mistreatment regarding client B, to develop and implement safeguards to prevent further incidents of injury of client A during showering and address staff's failure to immediately report an allegation of staff mistreatment of client B and to ensure the facility's nursing services met the health needs of client A.</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent neglect of client A during bathing/showering, to ensure an allegation of staff mistreatment regarding client B was immediately reported to the TL (Team Leader), to thoroughly investigate an IOU (Injury of Unknown Origin) regarding client A and an allegation of staff mistreatment regarding client B, to develop and implement safeguards to prevent further incidents of injury of client A during showering and address staff's failure to immediately report an allegation of staff mistreatment of client B. Please see W149.</p>		<p>High Risk Plan for Client A was reviewed and revised to include all safeguards and instruction for showering and bathing and further fall/injury prevention.</p> <p>High Risk Plan for all other individuals will be reviewed.</p> <p>Upon discovery of staff #2's admission to breach in procedure during the survey process, Director and Manager reopened the 11/19/14 investigation. Manager suspended staff #2 immediately upon discovery of breach in procedure. Manager interviewed all other staff that day to ensure all others were following the established procedure and risk plan for Client A. Staff #2 met with Director and Manager on 12/29/14 after 3 day disciplinary suspension to review all expectations surrounding following established safety procedures. Staff #2 was given specific direction on the morning routine and was observed 12/30/14 upon return to work on 12/30/14 to be completing this accurately.</p> <p>Staff will be retrained on all fall risk plans and morning routine expectations at mandatory staff training meeting, January 13, 2015.</p> <p>Direct observation of client personal care will continue by QIDP and TL to ensure compliance. Unannounced</p>	

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	<p>2. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure staff immediately reported client B's sister's allegation of staff mistreatment of client B to the TL or the facility's administrator in accordance with state law. Please see W153.</p> <p>3. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure an IOU regarding client A and an allegation of staff mistreatment regarding client B were thoroughly investigated. Please see W154.</p> <p>4. The governing body failed to exercise general policy, budget and operating direction over the facility to develop and implement corrective action to prevent reoccurrence of further injury of client A regarding showering and staff's failure to immediately report an allegation of staff mistreatment of client B. Please see W157.</p> <p>5. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility's nursing services met the needs of client A. Please see W331.</p>		<p>weekly visits will occur for one month following the above mentioned observation.</p> <p>New Hope of Indiana Group Home leadership staff will be retrained on the investigation process, specifically emphasizing the requirement to interview at minimum all personnel involved in the last 24 hours and include any recommendation for deficiency or incompetence in the investigation summary.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure these deficient practices do not recur? How the corrective actions will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place?</i></p> <p>Nursing staff will review requirements and noted deficiencies for all risk plans.</p> <p>Director will review all current risk plans and any future risk plans prior to implementation.</p> <p>Manager/QIDP and Team Leader will develop a specific morning routine schedule. Schedule will ensure that staffing and tasks are appropriately timed for client safety.</p> <p>Quality Assurance will review all investigation requirements and noted deficiencies for</p>				

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W000122	<p>This federal tag relates to complaint #IN00159834.</p> <p>9-3-1(a)</p> <p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview, the facility failed to meet the Condition of Participation: Client Protections for 2 of 2 sampled clients (A and B), the facility failed to implement its policy and procedures to prevent neglect of client A during bathing/showering, to ensure an allegation of staff mistreatment regarding client B was immediately reported to the TL (Team Leader), to thoroughly investigate an IOU (Injury of Unknown Origin) regarding client A and an allegation of staff mistreatment regarding client B, to develop and implement safeguards to prevent further incidents of injury of client A during showering and</p>	W000122	<p>investigations.</p> <p>Director and Quality Assurance will continue to review all investigations for thorough completion, specifically noting all possible informants are interviewed and any deficiencies are noted in the recommendation section. Director will create a review document to assist in checking that all elements of a thorough investigation are completed. Document will be signed by Director and included in all investigation folders.</p> <p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice? How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?</i></p> <p>High Risk Plan for Client A was reviewed and revised to include all safeguards and instruction for showering and bathing and further fall/injury prevention.</p> <p>High Risk Plan for all other individuals will be reviewed.</p>	01/22/2015

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	<p>address staff's failure to immediately report an allegation of staff mistreatment of client B.</p> <p>Findings include:</p> <p>1. The facility failed to implement its policy and procedures to prevent neglect of client A during bathing/showering, to ensure an allegation of staff mistreatment regarding client B was immediately reported to the TL (Team Leader), to thoroughly investigate an IOU (Injury of Unknown Origin) regarding client A and an allegation of staff mistreatment regarding client B, to develop and implement safeguards to prevent further incidents of injury of client A during showering and address staff's failure to immediately report an allegation of staff mistreatment of client B. Please see W149.</p> <p>2. The facility failed to ensure staff immediately reported client B's sister's allegation of staff mistreatment of client B to the TL or the facility's administrator in accordance with state law. Please see W153.</p> <p>3. The facility failed to ensure an IOU regarding client A and an allegation of staff mistreatment regarding client B were thoroughly investigated. Please see</p>		<p>Upon discovery of staff #2's admission to breach in procedure during the survey process, Director and Manager reopened the 11/19/14 investigation. Manager suspended staff #2 immediately upon discovery of breach in procedure. Manager interviewed all other staff that day to ensure all others were following the established procedure and risk plan for Client A. Staff #2 met with Director and Manager on 12/29/14 after 3 day disciplinary suspension to review all expectations surrounding following established safety procedures. Staff #2 was given specific direction on the morning routine and was observed 12/30/14 upon return to work on 12/30/14 to be completing this accurately.</p> <p>Staff will be retrained on all fall risk plans and morning routine expectations at mandatory staff training meeting, January 13, 2015.</p> <p>Direct observation of client personal care will continue by QIDP and TL to ensure compliance. Unannounced weekly visits will occur for one month following the above mentioned observation.</p> <p>New Hope of Indiana Group Home leadership staff will be retrained on the investigation process, specifically emphasizing the requirement to interview at minimum all personnel</p>	

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	<p>W154.</p> <p>4. The facility failed to develop and implement corrective action to prevent reoccurrence of further injury of client A regarding showering and prevent potential mistreatment of client B by staff's failure to immediately report an allegation of staff mistreatment of client B. Please see W157.</p> <p>This federal tag relates to complaint #IN00159834.</p> <p>9-3-2(a)</p>		<p>involved in the last 24 hours and include any recommendation for deficiency or incompetence in the investigation summary.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure these deficient practices do not recur? How the corrective actions will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place?</i></p> <p>Nursing staff will review requirements and noted deficiencies for all risk plans.</p> <p>Director will review all current risk plans and any future risk plans prior to implementation.</p> <p>Manager/QIDP and Team Leader will develop a specific morning routine schedule. Schedule will ensure that staffing and tasks are appropriately timed for client safety.</p> <p>Quality Assurance will review all investigation requirements and noted deficiencies for investigations.</p> <p>Director and Quality Assurance will continue to review all investigations for thorough completion, specifically noting all possible informants are interviewed and any deficiencies are noted in the recommendation section. Director will create a</p>	

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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 record review and interview for 2 of 2 sampled clients (A and B), the facility failed to implement its policy and procedures to prevent neglect of client A during bathing/showering, to ensure an allegation of staff mistreatment regarding client B was immediately reported to the TL (Team Leader), to thoroughly investigate an IOU (Injury of Unknown Origin) regarding client A and an allegation of staff mistreatment regarding client B, to develop and implement safeguards to prevent further incidents of injury of client A during showering and address staff's failure to immediately report an allegation of staff mistreatment of client B.</p> <p>Findings include:</p> <p>1. The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 12/18/14 at 1:06 PM. The review</p>	W000149	<p>review document to assist in checking that all elements of a thorough investigation are completed. Document will be signed by Director and included in all investigation folders.</p> <p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice? How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?</i></p> <p>High Risk Plan for Client A was reviewed and revised to include all safeguards and instruction for showering and bathing and further fall/injury prevention.</p> <p>High Risk Plan for all other individuals will be reviewed.</p> <p>Upon discovery of staff #2's admission to breach in procedure during the survey process, Director and Manager reopened the 11/19/14 investigation. Manager suspended staff #2 immediately upon discovery of breach in procedure. Manager interviewed all other staff that day to ensure all others were following the</p>	01/22/2015

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	<p>indicated the following:</p> <p>-BDDS report dated 11/20/14 indicated, "On 11/19/14, [DSP (Direct Support Staff) #1] had given [client A] a shower and was getting her dressed. [DSP #1] stated that when she started to put on [client A's] socks, [client A] jerked her leg back. [DSP #1] stated she then noticed [client A's] left foot/ankle was swollen. [DSP #1] notified [TL #1]. [Nurse Consultant #1] assessed [client A] and determined that [client A] needed a medical evaluation. [Client A] was taken to the ER (Emergency Room) where x-rays confirmed she has a fractured left ankle." The 11/20/14 BDDS report indicated, "RN (Registered Nurse) #1 will coordinate with [client A's] doctor and will update [client A's] FPP (Fall Prevention Plan) as needed."</p> <p>-Investigation Summary dated 11/19/14 regarding client A's 11/19/14 IUO did not indicate documentation of interviews being conducted with client A's day services staff.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 12/18/14 at 2:05 PM. QIDP #1 indicated client A had attended day services on 11/18/14. QIDP #1 indicated day services</p>		<p>established procedure and risk plan for Client A. Staff #2 met with Director and Manager on 12/29/14 after 3 day disciplinary suspension to review all expectations surrounding following established safety procedures. Staff #2 was given specific direction on the morning routine and was observed 12/30/14 upon return to work on 12/30/14 to be completing this accurately.</p> <p>Staff will be retrained on all fall risk plans and morning routine expectations at mandatory staff training meeting, January 13, 2015.</p> <p>Direct observation of client personal care will continue by QIDP and TL to ensure compliance. Unannounced weekly visits will occur for one month following the above mentioned observation.</p> <p>New Hope of Indiana Group Home leadership staff will be retrained on the investigation process, specifically emphasizing the requirement to interview at minimum all personnel involved in the last 24 hours and include any recommendation for deficiency or incompetence in the investigation summary.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure these deficient practices do not recur? How the corrective actions will be monitored</i></p>	

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	<p>staff had not been interviewed regarding client A's 11/19/14 IUO.</p> <p>Client A's record was reviewed on 12/23/14 at 10:17 AM. Client A's FPP dated 2/19/14 indicated client A diagnosis included, but was not limited to, Osteoporosis and she was wheelchair dependent. Client A's FPP dated 2/19/14 indicated, "[Client A] has a history of falls with injury. [Client A] is wheelchair bound and relies on a wheelchair to get around. [Client A] is a (sic) hoyer (lift). Also uses a shower chair to bathe." Client A's FPP dated 2/19/14 and updated on 12/23/14 did not indicate documentation of how staff should monitor and support client A during shower/bathing to prevent falls or injury.</p> <p>RN #1 was interviewed on 12/18/14 at 2:26 PM. RN #1 indicated she had updated client A's 2/19/14 FPP. RN #1 indicated client A's FPP should include supports necessary for client A to avoid further injury.</p> <p>DSP #2 was interviewed on 12/23/14 at 12:17 PM. DSP #2 indicated he had been working the overnight shift at the group home with client A on 11/19/14. DSP #2 stated, "I got [client A] up around 5:15 AM and put her in the shower chair and strapped her in. I then assisted clients B,</p>		<p><i>to ensure the deficient practice will not recur; what quality assurance program will be put into place?</i></p> <p>Nursing staff will review requirements and noted deficiencies for all risk plans.</p> <p>Director will review all current risk plans and any future risk plans prior to implementation.</p> <p>Manager/QIDP and Team Leader will develop a specific morning routine schedule. Schedule will ensure that staffing and tasks are appropriately timed for client safety.</p> <p>Quality Assurance will review all investigation requirements and noted deficiencies for investigations.</p> <p>Director and Quality Assurance will continue to review all investigations for thorough completion, specifically noting all possible informants are interviewed and any deficiencies are noted in the recommendation section. Director will create a review document to assist in checking that all elements of a thorough investigation are completed. Document will be signed by Director and included in all investigation folders.</p>	

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NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC				STREET ADDRESS, CITY, STATE, ZIP CODE 8521 CROWN POINT RD INDIANAPOLIS, IN 46278			
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	<p>C and D with getting up, bathing, dressing and medications. When the 6:00 AM staff (DSP #1) came in she showered client A." When asked if he had left client A unattended while strapped in the shower chair in the group home's shower area, DSP #2 stated, "Yes, I got her up and put her in the chair and then assisted the other clients. The 6:00 AM staff, [DSP #1], then assisted her shower at 6:00 AM." When asked how long client A was in the shower chair unattended, DSP #2 stated, "Like 10 or 15 minutes." DSP #2 stated, "Yes, this is the daily routine. I get [client A] up and put her in the shower and then move on to the others."</p> <p>QIDP #1 was interviewed on 12/23/14 at 12:27 PM. QIDP #1 stated, "He, [DSP #2], didn't tell me that he had left [client A] in the shower alone when I interviewed him for the investigation. They shouldn't be leaving [client A] alone in the shower chair. He, [DSP #2], should know better. That's why I have a second staff come in at 6:00 AM. [DSP #2] should get one client up at a time and wait for the second staff to come in before getting everyone up." QIDP #1 indicated client A should be one to one supervision during her shower/bathing time. When asked if client A's FPP specified how staff working with client A</p>						

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	<p>should supervise/support client A during bathing/shower time, QIDP #1 stated, "No, it's not specifically in there but it should be."</p> <p>2. BDDS report dated 12/1/14 indicated, "During a visit on 11/27/14, [Client B's] sister told [DSP #3] that [client B] has stated other staff, [DSP #4], were (sic) mean to her." The BDDS report indicated client B's sister made an allegation of staff mistreatment to DSP #3 on 11/27/14. The 12/1/14 BDDS report indicated the facility had knowledge of the allegation of staff mistreatment on 11/27/14.</p> <p>-Investigation Summary dated 11/27/14 regarding client B's sister's allegation of staff mistreatment did not indicate documentation of client B's sister being interviewed to determine her concerns and/or what client B had reported to her during client B's home visit. The 11/27/14 Investigation Summary did not address or indicate documentation of analysis of DSP #3's response to client B's sister's allegations. The 11/27/14 Investigation Summary did not indicate documentation of concerns and recommendations to address DSP #3's failure to report client B's sister's allegation of staff mistreatment immediately to the TL or</p>				

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	<p>on-call supervisor.</p> <p>DSP #3 was interviewed on 12/23/14 at 12:50 PM. DSP #3 indicated client B's sister reported an allegation of DSP #4 mistreating client B. When asked if he had reported client B's sister's allegation to his TL or supervisor on-call, DSP #3 stated, "No, I reported it to DSP #4. When DSP #4 came on for her shift later that afternoon I told her."</p> <p>TL #1 was interviewed on 12/23/14 at 12:55 PM. TL #1 indicated DSP #3 reported the allegation of DSP #4's mistreatment of client B to DSP #4 on 11/27/14. TL #1 indicated DSP #3 should have reported the allegation immediately to the TL. TL #1 indicated the allegation was reported to her on 12/1/14. TL #1 indicated when she was notified of the allegation on 12/1/14 she notified her manager/QIDP #1, suspended DSP #4 and began an investigation of the allegation.</p> <p>QIDP #1 was interviewed on 12/23/14 at 1:30 PM. QIDP #1 indicated the facility's abuse and neglect policy should be implemented. QIDP #1 indicated all allegations of abuse, neglect or mistreatment should immediately be reported to the TL or supervisor on-call and reported to BDDS within 24 hours of</p>						

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	<p>knowledge of the allegation. QIDP #1 indicated investigations regarding allegations of abuse, neglect, mistreatment or IUO should be thorough. QIDP #1 indicated corrective actions should be developed and implemented to prevent reoccurrence of IUO and alleged mistreatment.</p> <p>The facility's policy and procedures were reviewed on 12/18/14 at 3:00 PM. The facility's Suspected Abuse policy dated 7/2014 indicated, "Neglect is a practice that denies an individual any of the following without a physician's order: the repeated failure of a caregiver to provide supervision, training, appropriate care...." The facility's Suspected Abuse policy dated 7/2014 indicated, "If an associate suspects that an individual may be a victim of abuse, neglect or exploitation, the associate is required to contact his/her supervisor or the on-call team leader." The facility's Suspected Abuse policy dated 7/2014 indicated, "in the event a family member and/or guardian of an individual reports concerns regarding suspected abuse/neglect of an individual, the allegation will be investigated and documented." The 7/2014 Suspected Abuse policy indicated, "Any associate accused of abuse, neglect, exploitation, or mistreatment of an individual will be suspended pending an investigation. The</p>			

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W000153	<p>7/2014 Suspected Abuse policy indicated, "The TL or other designated associate will initiate the IUO Investigation Report to complete a thorough investigation as to how injury possibly occurred. The investigation must include interviews with staff who have worked with the individual in the past 24 hours. If individual is involved in day services or has a job, interviews at the program or job site must also occur."</p> <p>This federal tag relates to complaint #IN00159834.</p> <p>9-3-2(a)</p> <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. Based on record review and interview for 1 of 2 allegations of mistreatment and IUO (Injuries of Unknown Origin) reviewed, the facility failed to ensure facility staff immediately reported client B's sister's allegation of staff mistreatment of client B to the TL (Team</p>	W000153	<p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice? How will other residents having the potential to be affected by the same deficient practice be identified and what</i></p>	01/22/2015

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	<p>Leader) or the facility's administrator in accordance with state law.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 12/18/14 at 1:06 PM. The review indicated the following:</p> <p>-BDDS report dated 12/1/14 indicated, "During a visit on 11/27/14, [Client B's] sister told [DSP (Direct Support Staff) #3] that [client B] has stated other staff, [DSP #4], were (sic) mean to her." The BDDS report indicated client B's sister made an allegation of staff mistreatment to DSP #3 on 11/27/14. The 12/1/14 BDDS report indicated the facility had knowledge of the allegation of staff mistreatment on 12/1/14.</p> <p>DSP #3 was interviewed on 12/23/14 at 12:50 PM. DSP #3 indicated client B's sister reported an allegation of DSP #4 mistreating client B on 11/27/14. When asked if he had reported client B's sister's 11/27/14 allegation to his TL or supervisor on-call, DSP #3 stated, "No, I reported it to DSP #4. When DSP #4 came on for her shift later that afternoon I told her."</p>		<p><i>corrective action will be taken?</i></p> <p>New Hope of Indiana Group Home leadership staff will be retrained on the investigation process, specifically emphasizing the requirement to interview at minimum all personnel involved in the last 24 hours and include any recommendation for deficiency or incompetence in the investigation summary.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure these deficient practices do not recur? How the corrective actions will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place?</i></p> <p>Quality Assurance will review all investigation requirements and noted deficiencies for investigations.</p> <p>Director and Quality Assurance will continue to review all investigations for thorough completion, specifically noting all possible informants are interviewed and any deficiencies are noted in the recommendation section. Director will create a review document to assist in checking that all elements of a thorough investigation are completed. Document will be signed by Director and included in all investigation folders.</p>		

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W000154	<p>TL #1 was interviewed on 12/23/14 at 12:55 PM. TL #1 indicated DSP #3 reported the allegation of DSP #4's mistreatment of client B to DSP #4 on 11/27/14. TL #1 indicated DSP #3 should have reported the allegation immediately to the TL. TL #1 indicated the allegation was reported to her on 12/1/14. TL #1 indicated when she was notified of the allegation on 12/1/14 she notified her manager/QIDP (Qualified Intellectual Disabilities Professional) #1, suspended DSP #4 and began an investigation of the allegation.</p> <p>QIDP #1 was interviewed on 12/23/14 at 1:30 PM. QIDP #1 indicated all allegations of abuse, neglect or mistreatment should immediately be reported to the TL or supervisor on-call and reported to BDDS within 24 hours of knowledge of the allegation.</p> <p>This federal tag relates to complaint #IN00159834.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all</p>						

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	<p>alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 2 of 2 allegations of mistreatment and IUO (Injuries of Unknown Origin) reviewed, the facility failed to ensure an IOU (Injury of Unknown Origin) regarding client A and an allegation of staff mistreatment regarding client B were thoroughly investigated.</p> <p>Findings include:</p> <p>1. The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 12/18/14 at 1:06 PM. The review indicated the following:</p> <p>-BDDS report dated 11/20/14 indicated, "On 11/19/14, [DSP (Direct Support Staff) #1] had given [client A] a shower and was getting her dressed. [DSP #1] stated that when she started to put on [client A's] socks, [client A] jerked her leg back. [DSP #1] stated she then noticed [client A's] left foot/ankle was swollen. [DSP #1] notified [TL (Team Leader) #1]. [Nurse Consultant #1] assessed [client A] and determined that [client A] needed a medical evaluation. [Client A] was taken to the ER (Emergency Room) where x-rays confirmed she has a fractured left ankle."</p>	W000154	<p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice? How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?</i></p> <p>New Hope of Indiana Group Home leadership staff will be retrained on the investigation process, specifically emphasizing the requirement to interview at minimum all personnel involved in the last 24 hours and include any recommendation for deficiency or incompetence in the investigation summary.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure these deficient practices do not recur? How the corrective actions will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place?</i></p> <p>Quality Assurance will review all investigation requirements and noted deficiencies for investigations.</p> <p>Director and Quality Assurance will continue to review all investigations for thorough completion, specifically noting all possible informants are</p>	01/22/2015

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	<p>-Investigation Summary dated 11/19/14 regarding client A's 11/19/14 IUO did not indicate documentation of interviews being conducted with client A's day services staff.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 12/18/14 at 2:05 PM. QIDP #1 indicated client A had attended day services on 11/18/14. QIDP #1 indicated day services staff had not been interviewed regarding client A's 11/19/14 IUO.</p> <p>2. BDDS report dated 12/1/14 indicated, "During a visit on 11/27/14, [Client B's] sister told [DSP #3] that [client B] has stated other staff, [DSP #4], were (sic) mean to her."</p> <p>-Investigation Summary dated 11/27/14 regarding client B's sister's allegation of staff mistreatment did not indicate documentation of client B's sister being interviewed to determine her concerns and/or what client B had reported to her during client B's home visit. The 11/27/14 Investigation Summary did not address or indicate documentation of analysis of DSP #3's response to client B's sister's allegations.</p> <p>QIDP #1 was interviewed on 12/23/14 at</p>		<p>interviewed and any deficiencies are noted in the recommendation section. Director will create a review document to assist in checking that all elements of a thorough investigation are completed. Document will be signed by Director and included in all investigation folders.</p>	

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W000157	<p>1:30 PM. QIDP #1 indicated investigations regarding allegations of abuse, neglect, mistreatment or IUO should be thorough.</p> <p>This federal tag relates to complaint #IN00159834.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 2 of 2 allegations of mistreatment and IUO (Injuries of Unknown Origin) reviewed, the facility failed to develop and implement corrective action to prevent reoccurrence of further injury of client A regarding showering and staff's failure to immediately report an allegation of staff mistreatment of client B.</p> <p>Findings include:</p> <p>1. The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 12/18/14 at 1:06 PM. The review indicated the following:</p>	W000157	<p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice? How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?</i></p> <p>High Risk Plan for Client A was reviewed and revised to include all safeguards and instruction for showering and bathing and further fall/injury prevention.</p> <p>High Risk Plan for all other individuals will be reviewed.</p> <p>Staff will be retrained on all fall risk plans and morning routine</p>	01/22/2015

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	<p>-BDDS report dated 11/20/14 indicated, "On 11/19/14, [DSP (Direct Support Staff) #1] had given [client A] a shower and was getting her dressed. [DSP #1] stated that when she started to put on [client A's] socks, [client A] jerked her leg back. [DSP #1] stated she then noticed [client A's] left foot/ankle was swollen. [DSP #1] notified [TL (Team Leader) #1]. [Nurse Consultant #1] assessed [client A] and determined that [client A] needed a medical evaluation. [Client A] was taken to the ER (Emergency Room) where x-rays confirmed she has a fractured left ankle."</p> <p>The 11/20/14 BDDS report indicated, "RN (Registered Nurse) #1 will coordinate with [client A's] doctor and will update [client A's] FPP (Fall Prevention Plan) as needed."</p> <p>RN #1 was interviewed on 12/18/14 at 2:26 PM. RN #1 indicated she had updated client A's 2/19/14 FPP. RN #1 indicated client A's FPP should include supports necessary for client A to avoid further injury.</p> <p>Client A's record was reviewed on 12/23/14 at 10:17 AM. Client A's FPP dated 2/19/14 revised/updated on 12/23/14 indicated client A's diagnosis</p>		<p>expectations at mandatory staff training meeting, January 13, 2015.</p> <p>Direct observation of client personal care will continue by QIDP and TL to ensure compliance. Unannounced weekly visits will occur for one month following the above mentioned observation.</p> <p>New Hope of Indiana Group Home leadership staff will be retrained on the investigation process, specifically emphasizing the requirement to interview at minimum all personnel involved in the last 24 hours and include any recommendation for deficiency or incompetence in the investigation summary.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure these deficient practices do not recur? How the corrective actions will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place?</i></p> <p>Nursing staff will review requirements and noted deficiencies for all risk plans.</p> <p>Director will review all current risk plans and any future risk plans prior to implementation.</p> <p>Manager/QIDP and Team Leader will develop a specific morning routine schedule. Schedule will ensure that</p>	

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	<p>included, but was not limited to, Osteoporosis and she was wheelchair dependent. Client A's FPP dated 2/19/14 revised/updated on 12/23/14 indicated, "[Client A] has a history of falls with injury. [Client A] is wheelchair bound and relies on a wheelchair to get around. [Client A] is a (sic) hoier (lift). Also uses a shower chair to bathe." Client A's FPP dated 2/19/14 and updated on 12/23/14 did not indicate documentation of how staff should monitor and support client A during shower/bathing to prevent falls or injury.</p> <p>DSP #2 was interviewed on 12/23/14 at 12:17 PM. DSP #2 indicated he had been working the overnight shift at the group home with client A on 11/19/14. DSP #2 stated, "I got [client A] up around 5:15 AM and put her in the shower chair and strapped her in. I then assisted clients B, C and D with getting up, bathing, dressing and medications. When the 6:00 AM staff (DSP #1) came in she showered client A." When asked if he had left client A unattended while strapped in the shower chair in the group home's shower area, DSP #2 stated, "Yes, I got her up and put her in the chair and then assisted the other clients. The 6:00 AM staff, [DSP #1], then assisted her shower at 6:00 AM." When asked how long client A was in the shower chair unattended,</p>		<p>staffing and tasks are appropriately timed for client safety.</p> <p>Quality Assurance will review all investigation requirements and noted deficiencies for investigations.</p> <p>Director and Quality Assurance will continue to review all investigations for thorough completion, specifically noting all possible informants are interviewed and any deficiencies are noted in the recommendation section. Director will create a review document to assist in checking that all elements of a thorough investigation are completed. Document will be signed by Director and included in all investigation folders.</p>				

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	<p>DSP #2 stated, "Like 10 or 15 minutes." DSP #2 stated, "Yes, this is the daily routine. I get [client A] up and put her in the shower and then move on to the others."</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 12/23/14 at 12:27 PM. QIDP #1 stated, "He, [DSP #2], didn't tell me that he had left [client A] in the shower alone when I interviewed him for the investigation. They absolutely shouldn't be leaving [client A] alone in the shower chair. He, [DSP #2], should know better. That's why I have a second staff come in at 6:00 AM. [DSP #2] should get one client up at a time and wait for the second staff to come in before getting everyone up." QIDP #1 indicated client A should be one to one supervision during her shower/bathing time. When asked if client A's FPP specified how staff working with client A should supervise/support client A during bathing/shower time, QIDP #1 stated, "No, it's not specifically in there but it should be."</p> <p>2. BDDS report dated 12/1/14 indicated, "During a visit on 11/27/14, [Client B's] sister told [DSP #3] that [client B] has stated other staff, [DSP #4], were (sic) mean to her." The BDDS report indicated</p>			

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W000331	<p>client B's sister made an allegation of staff mistreatment to DSP #3 on 11/27/14. The 12/1/14 BDDS report indicated the facility had knowledge of the allegation of staff mistreatment on 11/27/14.</p> <p>-Investigation Summary dated 11/27/14 regarding client B's sister's allegation of staff mistreatment did not indicate documentation of concerns and recommendations to address DSP #3's failure to report client B's sister's allegation of staff mistreatment immediately to the TL or on-call supervisor.</p> <p>QIDP #1 was interviewed on 12/23/14 at 1:30 PM. QIDP #1 indicated corrective actions should be developed and implemented to prevent reoccurrence of IUO and alleged mistreatment.</p> <p>This federal tag relates to complaint #IN00159834.</p> <p>9-3-2(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing</p>			

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	<p>services in accordance with their needs. Based on record review and interview for 1 of 2 sampled clients (A), the facility's nursing services failed to met the needs of client A.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 12/18/14 at 1:06 PM. The review indicated the following:</p> <p>-BDDS report dated 11/20/14 indicated, "On 11/19/14, [DSP (Direct Support Staff) #1] had given [client A] a shower and was getting her dressed. [DSP #1] stated that when she started to put on [client A's] socks, [client A] jerked her leg back. [DSP #1] stated she then noticed [client A's] left foot/ankle was swollen. [DSP #1] notified [TL (Team Leader) #1]. [Nurse Consultant #1] assessed [client A] and determined that [client A] needed a medical evaluation. [Client A] was taken to the ER (Emergency Room) where x-rays confirmed she has a fractured left ankle." The 11/20/14 BDDS report indicated, "RN (Registered Nurse) #1 will coordinate with [client A's] doctor and will update [client A's] FPP (Fall Prevention Plan) as needed."</p>	W000331	<p>High Risk Plan for Client A was reviewed and revised to include all safeguards and instruction for showering and bathing and further fall/injury prevention.</p> <p>High Risk Plan for all other individuals will be reviewed.</p> <p>Staff will be retrained on all fall risk plans and morning routine expectations at mandatory staff training meeting, January 13, 2015.</p> <p>Direct observation of client personal care will continue by QIDP and TL to ensure compliance. Unannounced weekly visits will occur for one month following the above mentioned observation.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure these deficient practices do not recur? How the corrective actions will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place?</i></p> <p>Nursing staff will review requirements and noted deficiencies for all risk plans.</p> <p>Director will review all current risk plans and any future risk plans prior to implementation.</p>	01/22/2015

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	<p>Client A's record was reviewed on 12/23/14 at 10:17 AM. Client A's FPP dated 2/19/14 indicated client A diagnosis included, but was not limited to, Osteoporosis and she was wheelchair dependent. Client A's FPP dated 2/19/14 indicated, "[Client A] has a history of falls with injury. [Client A] is wheelchair bound and relies on wheelchair to get around. [Client A] is a (sic) hoyer (lift). Also uses a shower chair to bathe." Client A's FPP dated 2/19/14 and updated on 12/23/14 did not indicate documentation of how staff should monitor and support client A during shower/bathing to prevent falls or injury.</p> <p>RN #1 was interviewed on 12/18/14 at 2:26 PM. RN #1 indicated she had updated client A's 2/19/14 FPP. RN #1 indicated client A's FPP should include supports necessary for client A to avoid further injury.</p> <p>DSP #2 was interviewed on 12/23/14 at 12:17 PM. DSP #2 indicated he had been working the overnight shift at the group home with client A on 11/19/14. DSP #2 stated, "I got [client A] up around 5:15 AM and put her in the shower chair and strapped her in. I then assisted clients B, C and D with getting up, bathing, dressing and medications. When the 6:00</p>		<p>Manager/QIDP and Team Leader will develop a specific morning routine schedule. Schedule will ensure that staffing and tasks are appropriately timed for client safety.</p>		

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	<p>AM staff (DSP #1) came in she showered client A." When asked if he had left client A unattended while strapped in the shower chair in the group home's shower area, DSP #2 stated, "Yes, I got her up and put her in the chair and then assisted the other clients. The 6:00 AM staff, [DSP #1], then assisted her shower at 6:00 AM." When asked how long client A was in the shower chair unattended, DSP #2 stated, "Like 10 or 15 minutes." DSP #2 stated, "Yes, this is the daily routine. I get [client A] up and put her in the shower and then move onto the others."</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 12/23/14 at 12:27 PM. QIDP #1 stated, "He, [DSP #2], didn't tell me that he had left [client A] in the shower alone when I interviewed him for the investigation. They absolutely shouldn't be leaving [client A] alone in the shower chair. QIDP #1 indicated client A should be one to one supervision during her shower/bathing time. When asked if client A's FPP specified how staff working with client A should supervise/support client A during bathing/shower time, QIDP #1 stated, "No, it's not specifically in there but it should be."</p>			

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	This federal tag relates to complaint #IN00159834. 9-3-6(a)				