

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G487	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/31/2015
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NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4822 ALAMEDA ST INDIANAPOLIS, IN 46208
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W 0000 Bldg. 00	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: 7/27/15, 7/28/15, 7/29/15, 7/30/15 and 7/31/15</p> <p>Facility Number: 001001 Provider Number: 15G487 AIMS Number: 100245000</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0268 Bldg. 00	<p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT</p> <p>These policies and procedures must promote the growth, development and independence of the client.</p> <p>Based on observation, record review and interview for 1 of 4 sampled clients (#3), the facility failed to promote the dignity of client #3.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 7/28/15 from 4:00 PM through 5:15 PM. Client #3 was observed</p>	W 0268	<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>QIDP created an informal cueing goal to Client #3's ISP. It was</p>	08/17/2015

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>throughout the observation period. Client #3 had saliva drooling from his mouth throughout the observation period. Client #3 was not prompted/encouraged to wipe his saliva from his mouth.</p> <p>Observations were conducted at the group home on 7/29/15 from 6:15 AM through 8:07 AM. Client #3 was observed throughout the observation period. Client #3 had saliva drooling from his mouth throughout the observation period.</p> <p>Client #3's record was reviewed on 7/28/15 at 3:00 PM. Client #3's record did not indicate documentation of a formal or informal training program to address client #3's drooling.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 7/29/15 at 11:40 AM. QIDP #1 indicated client #3 received medication to reduce his drooling and has had formal training programs to address his drooling. QIDP #1 indicated client #3 had not made progress in achieving goals addressing his drooling which led to the cessation of the formal program. QIDP #1 indicated client #3 was redirected from activities involving contact with his peers' food such as meal preparation.</p>		<p>integrated on 8/13/2015 and acknowledged by all staff working in the facility. Staff document this on each shift and integrate the training opportunity throughout the shift as indicated.</p> <p>Client #3 also was reviewed by neurology to see if all medication approaches to minimize drooling have been approached. Neurology declined any further medication approach, continue current dosage.</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>All Group Home leadership have reviewed this issue and will reassess any other individuals who may have drooling issues that need further discussion. QIDP and Team Leader will conduct weekly observations to ensure that staff are offering cues to client #3 as appropriate and that all aspects of each individuals' dignity is being maintained.</p>	

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W 0436 Bldg. 00	<p>9-3-5(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review and interview for 1 of 5 clients with adaptive equipment (#3), the facility failed to ensure client #3 utilized his gait belt.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 7/28/15 from 4:00 PM through 5:15 PM. Client #3 was observed throughout the observation period. Client #3 did not wear a gait belt while walking/ambulating in the home.</p> <p>Observations were conducted at the group home on 7/29/15 from 6:15 AM through 8:07 AM. Client #3 was observed throughout the observation period. Client #3 did not wear a gait belt while walking/ambulating in the home.</p> <p>Client #3's record was reviewed on 7/28/15 at 3:00 PM. Client #3's ISP (Individual Support Plan) dated 8/4/14</p>	W 0436	<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>IDT reassessed Client #3 PT evaluation and need for gait belt. It was not deemed necessary and removed from High Risk Plan. All other individuals were reviewed to ensure High Risk Plan included the appropriate use and schedule for adaptive equipment. Staff were offering the appropriate support and HRP was not updated when revised.</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</i></p>	08/17/2015

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	<p>indicated client #3 should utilize a gait belt while at the group home. Client #3's Fall Risk Protocol dated 5/2/15 indicated client #3 should wear a gait belt while in the group home.</p> <p>TL (Team Leader) #1 was interviewed on 7/29/15 at 11:42 AM. TL #1 indicated client #3 did not wear a gait belt while in the group home. TL #1 indicated client #3's Fall Risk Plan indicated client #3 should wear a gait belt while walking in the group home.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 7/29/15 at 11:45 AM. QIDP #1 indicated client #3's Fall Risk Plan indicated client #3 should use a gait belt while in the group home.</p> <p>9-3-7(a)</p>		<p><i>program will be put into place?</i></p> <p>QIDP will be solely responsible for coordinating the ISP. New Hope will not assign QIDP designees to coordinate the ISP. QIDP will continue to update each ISP as any recommendation may change. Issue was reviewed with Group Home QIDP group for all facilities. Director will review all HRPs upon creation and revision.</p>	