

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G563	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/31/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2999 WESTLANE RD INDIANAPOLIS, IN 46268
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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: 001077 Provider Number: 15G563 AIMS Number: 100245490</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0126 Bldg. 00	<p>483.420(a)(4) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.</p> <p>Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), the facility failed to utilize United States (US) currency in their formal money management programs.</p> <p>Findings include:</p> <p>Observations were conducted at the</p>	W 0126	<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>All simulated versions of money and currency were removed from the</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G563	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/31/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2999 WESTLANE RD INDIANAPOLIS, IN 46268
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>group home on 7/27/15 from 3:53 PM through 5:46 PM. At 5:00 PM, client #1 was encouraged to participate in money management training with staff #1 at the dining room table. Staff #1 utilized a cash drawer with replica dollar bills and plastic replica coins.</p> <p>1. Client #1's record was reviewed on 7/28/15 at 9:57 AM. Client #1's ISP (Individual Support Plan) dated 6/25/14 indicated client #1 had a money management training objective to make change for \$5.00 with verbal prompts.</p> <p>2. Client #2's record was reviewed on 7/28/15 at 10:08 AM. Client #2's ISP dated 7/16/14 indicated client #2 had a money management training objective to identify a \$1.00 bill.</p> <p>3. Client #3's record was reviewed on 7/28/15 at 10:40 AM. Client #3's ISP dated 9/16/14 indicated client #3 had a money management training objective to identify a quarter with verbal cues.</p> <p>4. Client #4's record was reviewed on 7/28/15 at 10:23 AM. Client #4's ISP dated 7/16/14 indicated client #4 had a money management training objective to identify a dime with verbal cues.</p> <p>TL (Team Leader) #1 was interviewed on</p>		<p>home.</p> <p>QIDP revised 8 of 8 client ISPs to direct money management and financial training to community based interactions. All staff have reviewed and acknowledged the revised ISPs as of 8/14/2015.</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 discontinue financial training goals that do not utilize community based real life training transactions. QIDP will be responsible to review and approve all goals to ensure they are consistent with the functional assessment and conducive to functional training opportunities.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G563	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/31/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2999 WESTLANE RD INDIANAPOLIS, IN 46268
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0159 Bldg. 00	<p>7/28/15 at 12:57 PM. TL #1 indicated the home utilized replica US currency in their money management training program. TL #1 indicated clients #1, #2, #3 and #4 had money management training objectives.</p> <p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), the QIDP (Qualified Intellectual Disabilities Professional) failed to integrate, coordinate and monitor clients #1, #2, #3 and #4's active treatment programs by failing to ensure the facility utilized US (United States) currency in their formal money management programs, by failing to ensure client #1's CFA (Comprehensive Functional Assessment) was reviewed annually, by failing to ensure client #1's ISP (Individual Support Plan) was reviewed annually, by failing to ensure the facility's HRC (Human Rights Committee) reviewed, approved and monitored client #3's use of psychotropic medications for the management of client</p>	W 0159	Please see W126 W159 W259 W260 W262 W263 W312 W382	08/17/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G563	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/31/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2999 WESTLANE RD INDIANAPOLIS, IN 46268
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>#3's behavior, by failing to ensure client #3's guardian gave written informed consent for the use of psychotropic medication to manage client #3's behavior, by failing to ensure client #3's use of psychotropic medication for behavior management was incorporated into her active treatment plan to reduce or eliminate the need for the use of the psychotropic medication and by failing to ensure client #3 independently consumed her meal to the extent of her capabilities.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The QIDP failed to integrate, coordinate and monitor clients #1, #2, #3 and #4's active treatment programs by failing to ensure the facility utilized US currency in their formal money management programs. Please see W126. 2. The QIDP failed to integrate, coordinate and monitor client #1's active treatment program by failing to ensure client #1's CFA was reviewed annually. Please see W259. 3. The QIDP failed to integrate, coordinate and monitor client #1's active treatment program by failing to ensure client #1's ISP was reviewed annually. Please see W260. 			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G563	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/31/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2999 WESTLANE RD INDIANAPOLIS, IN 46268
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>4. The QIDP failed to integrate, coordinate and monitor client #3's active treatment program by failing to ensure the facility's HRC (Human Rights Committee) reviewed, approved and monitored client #3's use of psychotropic medications for the management of client #3's behavior. Please see W262.</p> <p>5. The QIDP failed to integrate, coordinate and monitor client #3's active treatment program by failing to ensure client #3's guardian gave written informed consent for the use of psychotropic medication to manage client #3's behavior. Please see W263.</p> <p>6. The QIDP failed to integrate, coordinate and monitor client #3's active treatment program by failing to ensure client #3's use of psychotropic medication for behavior management was incorporated into her active treatment plan to reduce or eliminate the need for the use of the psychotropic medication. Please see W312.</p> <p>7. The QIDP failed to integrate, coordinate and monitor client #3's active treatment program by failing to ensure client #3 independently consumed her meal to the extent of her capabilities. Please see W488.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G563	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/31/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2999 WESTLANE RD INDIANAPOLIS, IN 46268
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0259 Bldg. 00	<p>9-3-3(a)</p> <p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview for 1 of 4 sampled clients (#1), the facility failed to ensure client #1's CFA (Comprehensive Functional Assessment) was reviewed annually.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 7/28/15 at 9:37 AM. Client #1's CFA dated 5/29/13 did not indicate documentation of annual review since 5/29/13.</p> <p>TL (Team Leader) #1 was interviewed on 7/28/15 at 12:57 PM. TL #1 indicated there was not additional documentation of client #1's CFA being reviewed annually since 5/29/13.</p> <p>9-3-4(a)</p>	W 0259	<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>Comprehensive Functional Assessment for Client #1 was completed and reviewed by guardian and IDT.</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>QIDP team reviewed issue and will be solely responsible for CFA and ISP. No further Q designee assignments will be used to complete the coordination of the assessment and training program.</p>	08/17/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G563	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/31/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2999 WESTLANE RD INDIANAPOLIS, IN 46268
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0260 Bldg. 00	<p>483.440(f)(2) PROGRAM MONITORING & CHANGE</p> <p>At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.</p> <p>Based on record review and interview for 1 of 4 sampled clients (#1), the facility failed to ensure client #1's ISP (Individual Support Plan) was reviewed annually.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 7/28/15 at 9:37 AM. Client #1's ISP dated 6/24/14 did not indicate documentation of annual review since 6/24/14.</p> <p>TL (Team Leader) #1 was interviewed on 7/28/15 at 12:57 PM. TL #1 indicated there was not additional documentation of client #1's ISP being reviewed annually since 6/24/14.</p> <p>9-3-4(a)</p>	W 0260	<p>This was effective 8/1/15. It is our belief that this will vastly improve the consistency and completion of ISP and the supporting features.</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>ISP for Client #1 was completed and reviewed by guardian and IDT.</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>QIDP team reviewed issue and will be solely responsible for CFA and ISP. No further Q designee assignments will be used to complete the coordination of the assessment and training program.</p>	08/17/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G563	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/31/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2999 WESTLANE RD INDIANAPOLIS, IN 46268
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0262 Bldg. 00	<p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on record review and interview for 1 of 4 sampled clients (#3), the facility failed to ensure the facility's HRC (Human Rights Committee) reviewed, approved and monitored client #3's use of psychotropic medications for the management of client #3's behavior.</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 7/28/15 at 10:40 AM. Client #3's Physician's Orders form dated 6/24/15 indicated, "Divalproex (seizures/mood stabilization) tablet 250 milligrams ER (Extended Release). Give three tablets/750 milligrams by mouth every night at bedtime for seizures."</p> <p>Client #3's Psychiatric Review form dated 9/2012 indicated client #3 received Depakote/Divalproex ER as a mood</p>	W 0262	<p>This was effective 8/1/15. It is our belief that this will vastly improve the consistency and completion of ISP and the supporting features.</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>BSP for Client was updated to include the neuroleptic medication that is serving a possible dual purpose for her history of seizures and mood disorder. This is the only medication that could have mood alteration that she takes. All other individuals have had BSPs reviewed and all medications have been noted to be appropriately integrated in plan, with all corresponding consents and rights reviews.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure these deficient</i></p>	08/17/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G563		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/31/2015	
NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2999 WESTLANE RD INDIANAPOLIS, IN 46268			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W 0263 Bldg. 00	<p>stabilizer secondary to seizures.</p> <p>Client #3's record did not indicate documentation of HRC review, approval or monitoring of client #3's use of Divalproex for the management of client #3's behavior.</p> <p>Nurse #1 was interviewed on 7/28/15 at 1:05 PM. Nurse #1 indicated client #3 received Divalproex for both seizures and behavior management.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on record review and interview for 1 of 4 sampled clients (#3), the facility failed to ensure client #3's guardian gave written informed consent for the use of psychotropic medication to manage client #3's behavior.</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 7/28/15 at 10:40 AM. Client #3's Physician's Orders form dated 6/24/15</p>	W 0263	<p><i>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>Director will continue to complete monthly BSP review. Included in that review will be specific review to any medication that neurology is managing which might have dual purposes as this.</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>BSP for Client was updated to include the neuroleptic medication that is serving a possible dual purpose for her history of seizures and mood disorder. All consents</p>	08/17/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G563	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/31/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2999 WESTLANE RD INDIANAPOLIS, IN 46268
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0312 Bldg. 00	<p>indicated, "Divalproex (seizures/mood stabilization) tablet 250 milligrams ER (Extended Release). Give three tablets/750 milligrams by mouth every night at bedtime for seizures."</p> <p>Client #3's Psychiatric Review form dated 9/2012 indicated client #3 received Depakote/Divalproex ER as a mood stabilizer secondary to seizures.</p> <p>Client #3's ISP (Individual Support Plan) dated 9/16/14 indicated client #3 had a legal guardian.</p> <p>Client #3's record did not indicate documentation of client #3's guardian's written informed consent for the use of Divalproex/Depakote to manage client #3's behavior.</p> <p>Nurse #1 was interviewed on 7/28/15 at 1:05 PM. Nurse #1 indicated client #3 received Divalproex for both seizures and behavior management.</p> <p>9-3-4(a)</p> <p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the</p>		<p>and approvals have been obtained and all staff have been trained on the new plan. This is the only medication that could have mood alteration that she takes. All other individuals have had BSPs reviewed and all medications have been noted to be appropriately integrated in plan, with all corresponding consents and rights reviews.</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>Director will continue to complete monthly BSP review. Included in that review will be specific review to any medication that neurology is managing which might have dual purposes as this.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G563	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/31/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2999 WESTLANE RD INDIANAPOLIS, IN 46268
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for 1 of 4 sampled clients (#3), the facility failed to ensure client #3's use of psychotropic medication for behavior management was incorporated into her active treatment plan to reduce or eliminate the need for the use of the psychotropic medication.</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 7/28/15 at 10:40 AM. Client #3's Physician's Orders form dated 6/24/15 indicated, "Divalproex (seizures/mood stabilization) tablet 250 milligrams ER (Extended Release). Give three tablets/750 milligrams by mouth every night at bedtime for seizures."</p> <p>Client #3's Psychiatric Review form dated 9/2012 indicated client #3 received Depakote/Divalproex ER as a mood stabilizer secondary to seizures.</p> <p>Client #3's BSP (Behavior Support Plan) dated 2/1/15 did not indicate documentation of the use of Divalproex for mood stabilization or behavior management.</p> <p>Client #3's ISP (Individual Support Plan)</p>	W 0312	<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>BSP for Client was updated to include the neuroleptic medication that is serving a possible dual purpose for her history of seizures and mood disorder. All consents and approvals have been obtained and all staff in facility have reviewed the new plan. This is the only medication that could have mood alteration that she takes. All other individuals have had BSPs reviewed and all medications have been noted to be appropriately integrated in plan, with all corresponding consents and rights reviews.</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>Director will continue to complete monthly BSP review. Included in that review will be specific review to</p>	08/17/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G563	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/31/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2999 WESTLANE RD INDIANAPOLIS, IN 46268
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0382 Bldg. 00	<p>dated 9/16/14 did not indicate documentation of the use of Divalproex for mood stabilization or behavior management.</p> <p>Nurse #1 was interviewed on 7/28/15 at 1:05 PM. Nurse #1 indicated client #3 received Divalproex for both seizures and behavior management.</p> <p>TL (Team Leader) #1 was interviewed on 7/28/15 at 12:57 PM. TL #1 indicated client #3's BSP dated 2/1/15 did not include the use of Depakote/Divalproex to manage client #3's behavior.</p> <p>9-3-5(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation, record review and interview for 1 of 4 sampled clients (#4), the facility failed to ensure client #4's prescription mouthwash was secured when not being used.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 7/28/15 from 6:15 AM</p>	W 0382	<p>any medication that neurology is managing which might have dual purposes as this.</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>Staff were retrained on the appropriate use and monitoring of</p>	08/17/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G563	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/31/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2999 WESTLANE RD INDIANAPOLIS, IN 46268
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>through 8:00 AM. At 7:30 AM, client #4 was prompted to enter the medication administration office to receive her morning medications. Client #4 received her morning medications and exited the medication administration office with a souffle cup of blue/green liquid. Client #4 sat the cup on the arm of a couch located near the dining area and sat down at the dining room table. Clients #1, #2, #3, #5, #6 and #7 were in the area while the cup of liquid was unsecured on the arm rest of the couch. At 7:34 AM, client #1 walked past the couch, noticed the cup and stated, "Somebody left their mouthwash out." Staff #2 directed client #1 to hand the cup to client #4 and indicated the cup contained client #4's mouthwash. Staff #2 directed client #4 to take the mouthwash to the bathroom and complete her oral hygiene.</p> <p>Client #4's record was reviewed on 7/28/15 at 10:23 AM. Client #4's Physicians Order's form dated 6/24/15 indicated client #4 had a prescription for Chlorhexidine Gluconate 0.12% Oral Rinse Solution (Gingivitis).</p> <p>TL (Team Leader) #1 was interviewed on 7/28/15 at 12:57 PM. TL #1 indicated client #4 set her Chlorhexidine Gluconate mouthwash on the couch and left it unattended. TL #1 indicated staff should</p>		<p>mouthwash when individuals require it in their plan. Staff also reviewed the requirement for all medications and treatments to remain locked unless prepared for administration.</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>Team Leader will conduct med observation on 8/13 and 8/14 after training and then weekly thereafter to ensure that staff continue to apply training to the task in the home.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G563	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/31/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2999 WESTLANE RD INDIANAPOLIS, IN 46268
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0488 Bldg. 00	<p>ensure all prescription medications are secured when not being administered.</p> <p>Nurse #1 was interviewed on 7/28/15 at 1:05 PM. Nurse #1 indicated Chlorhexidine Gluconate was a prescription mouthwash and should be secured while not being administered.</p> <p>9-3-6(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE</p> <p>The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation, record review and interview for 1 of 4 sampled clients (#3), the facility failed to ensure client #3 independently consumed her meal to the extent of her capabilities.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 7/28/15 from 6:15 AM through 8:00 AM. Client #3 participated in the home's family style morning meal from 7:00 AM through 7:45 AM. Staff #2 spoon fed client #3 her oatmeal and held client #3's cup to drink her milk. Client #3 was not encouraged to feed herself or hold her own cup while</p>	W 0488	<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 has elected to request an updated OT evaluation specific to supports needed for eating. While that assessment is being completed, QIDP has incorporated a goal into her ISP to participate in the first few minutes of eating by using utensil or allowing HOH support. After those few minutes, staff will be able to offer more support according to her</p>	08/17/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G563	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/31/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2999 WESTLANE RD INDIANAPOLIS, IN 46268
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>drinking.</p> <p>Client #3's record was reviewed on 7/28/15 at 10:40 AM. Client #3's Functional Skills Assessment dated 9/16/14 indicated client #3 use a fork or spoon to feed herself with physical assistance/HOH (Hand over Hand) from staff.</p> <p>TL (Team Leader) #1 was interviewed on 7/28/15 at 12:57 PM. TL #1 indicated client #3 could feed herself with physical assistance from staff. TL #1 indicated client #3 had spasticity issues (muscle tightness) but should be offered hand over hand assistance as she is able/willing.</p> <p>9-3-8(a)</p>		<p>mood and spasticity. No other individuals in the home were affected by the inability to feed themselves.</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>Team Leader will conduct meal observation on 8/13 and 8/14 after training and then weekly thereafter to ensure that staff continue to apply training to the task in the home.</p>	