

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G076	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 515 S 10TH ST NOBLESVILLE, IN 46060
---	---

(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
W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: 10/6, 10/7, 10/8, 10/9, 10/10, and 10/17/2014.</p> <p>Facility Number: 000620 Provider Number: 15G076 AIMS Number: 100233810</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed October 29, 2014 by Dotty Walton, QIDP.</p>	W000000		
W000153	<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.</p> <p>Based on record review and interview, for 2 of 2 allegations reported to BDDS (Bureau of Developmental Disabilities Services) reviewed (Discharged Client #8), the facility staff failed to immediately report an allegation of staff</p>	W000153	<p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice?</i></p> <p>The 9/29/13 incident was reported</p>	11/16/2014

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: 15G076		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/17/2014	
NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 515 S 10TH ST NOBLESVILLE, IN 46060			
(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>to client allegation of abuse to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law 9-3-1(b)(5) and failed to report an allegation of abuse by Discharged client #8 toward clients #2 and #6 resulting in the families removing their clients.</p> <p>Findings include:</p> <p>1. On 10/6/14 at 8:00pm and on 10/7/14 at 10:20am, the facility's BDDS Reports and investigations were reviewed from 10/1/13 through 10/06/14. The review indicated the following for Discharged Client #8:</p> <p>-An 10/1/13 BDDS report for an incident reported on 9/29/13 at 6:00pm. The BDDS report indicated "It was reported by [Discharged Client #8] that [Group Home Staff (GHS) #1] yelled and cussed at [Discharged Client #8]. [GHS #1] was suspended pending results of investigation (sic)."</p> <p>-A 11/22/13 Follow Up BDDS report indicated "Regarding investigation into verbal abuse allegation, the committee determined it was substantiated. [GHS #1] was upset and frustrated with the actions of [Discharged Client #8] and was also afraid for [Discharged Client</p>		<p>late and retraining had occurred immediately with both staff present. No further reports have been late or inaccurately reported.</p> <p>The 3/25/14 incident was reported as indicated. NHI did not support the necessity for Client #2 and Client #6 to be removed. The level of severity and danger of this situation was perceived far differently by Client #2 and #6 families. NHI was made aware that the families were choosing to keep their loved ones at home until Client #8 was moved. Subsequent meeting with BDDS was arranged to assist family in understanding the steps NHI was taking to continue serving all 3 women safely. In the future any resident of the facility that is removed from the facility due to family concern will be reported and investigated.</p> <p><i>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 staff will be retrained on reporting timely, reporting all indications or allegations of abuse, neglect or exploitation. In addition, all further indications that a family is removing their loved one from the home will be reported and investigated.</p> <p><i>What measures will be put into</i></p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G076	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 515 S 10TH ST NOBLESVILLE, IN 46060
---	---

(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>#8] so she yelled at her in an attempt to get [Discharged Client #8] to respond differently."</p> <p>-The facility's 10/1/13 Investigation into the 9/29/13 indicated the "Team Leader" of the group home interviewed Discharged Client #8, GHS #1, clients #2 and #6, and a second facility staff. The facility staff failed to immediately report an allegation of staff abuse on 9/29/13.</p> <p>On 10/17/14 at 10:03am, an interview was conducted with the facility's Group Home Manager/Qualified Intellectual Disabilities Professional (GHM/QIDP). The GHM/QIDP indicated the facility followed the BDDS reporting policy and procedure. The GHM/QIDP indicated the facility staff did not immediately report Discharged Client #8's allegation of staff abuse and should have.</p> <p>2. On 10/6/14 at 8:00pm and on 10/7/14 at 10:20am, the facility's BDDS Reports and investigations were reviewed from 10/1/13 through 10/06/14. The review indicated the following aggression by Discharged Client #8 toward clients #2 and #6.</p> <p>-A 3/25/14 BDDS report for an incident on 3/24/14 at 3:45pm, indicated a "[Client #6] was returning to her room</p>		<p><i>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>New Hope Quality Assurance Department continues to track and monitor all incident reports, highlighting late reporting. The Director receives and reviews all incident reports as well as the tracking spreadsheet. Late reporting is recorded in personnel records and trends are addressed accordingly. Group Home Director will also continue to review all reports to ensure any parental or representative concern for safety is reported.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G076	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 515 S 10TH ST NOBLESVILLE, IN 46060
---	---

(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>after taking a shower. [Discharged Client #8] was in her room at the time, while [client #6] was starting to open her door, [Discharged Client #8] came out of her room and yelled at [client #6] Why are you looking at me Expletive. Staff ran upstairs and got in front of [Discharged Client #8] to block her from [client #6]... [Client #6] went into her room while staff was with [Discharged Client #8]." The report indicated client #6's roommate (client #2) who exited their shared bedroom to wash her hands in the bathroom while Discharged Client #8 continued to have behaviors. The report indicated Discharged Client #8 "continued" to be "involved in verbal aggression" and clients were in their rooms. Staff told client #2 "when she was done washing hands to come that they would go downstairs as it was her night to cook (sic). Staff turned to go downstairs with [client #2], before [client #2] could fully get out of bathroom [Discharged Client #8] flew out of her room into the bathroom screaming and hit [client #2] across chest, [client #2] hit [Discharged Client #8] across chest" before staff could step between the clients. The report indicated Discharged Client #8 "continued" the verbal aggression for "approximately 10 minutes." The report indicated "both [clients #2 and #6] involved called family</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G076	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 515 S 10TH ST NOBLESVILLE, IN 46060
---	---

(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>members after [Discharged Client #8] went to her room. One of the family members called the Police. The police came to the group home. The families arrived at the group home a little while later...Both [clients #2 and #6] went home with their parents for the rest of the evening and overnight...."</p> <p>On 10/7/14 at 10:20am, a review was conducted of Discharged Client #8's 4/16/14 narrative listing of events documented by the GHM/QIDP indicated the following:</p> <ul style="list-style-type: none"> -On 4/16/14, Discharged Client #8 moved out of the group home. -On 4/9/14, Client #2's parent "called asking about current progress" for Discharged Client #8 to be moved from the group home. Client #2's parent stated to the GHM/QIDP "that she was very disappointed in NHI (New Hope Indiana) response to this. That something should have been done a long time ago and faster but that administration and the power that be can pick and choose what they want to have happen. [Client #2's parent] indicated she had already spoken with the home and made arrangements for her daughter to return Sunday, 4/13/14." -On 4/7/14, Client #6's parent "called [GHM/QIDP] to inform me that her 			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G076		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/17/2014	
NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 515 S 10TH ST NOBLESVILLE, IN 46060			
(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>daughter (client #6) would be returning to the group home this evening after [Workshop]. She said she didn't want this to change anything about [Discharged Client #8] moving. [GHM/QIDP] informed her that it was [Discharged Client #8's] desire to move and NH is supporting her in that transition. Her daughter returning to the home would have no impact on changing that."</p> <p>-On 4/1/14, Client #6's parent was called "to discuss continued plans. Informed her that the funding was approved but that [Discharged Client #8] remained in her home until further notice. She indicated that she would keep her daughter home."</p> <p>-On 4/1/14, Client #2's parent was contacted by the GHM/QIDP "Informed her of same information. She elected to keep her daughter at her home."</p> <p>-On 3/28/14, a meeting with client #2's parent, client #6's parents, the BDDS Coordinator, and the GHM/QIDP was held "to discuss their concerns with the group home and the options they have. The meeting was held at their request based on their choice to take their children home until [Discharged Client #8] is moved from the home...Each family spent time verbalizing their concerns with the situation. They indicated that they see [Discharged Client</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G076		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/17/2014	
NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 515 S 10TH ST NOBLESVILLE, IN 46060			
(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>#8] as violent, crazy, and in need of psychiatric hospitalization. They indicated that they do not feel that their children are protected and want [Discharged Client #8] removed from the home."</p> <p>-On 3/28/14, received notice that Discharged Client #8's waiver placement was approved by BDDS.</p> <p>-On 3/25/14, GHM/QIDP "spoke with both parents regarding incident and their thoughts for resolution. Most frequently indicated were the desire for [Discharged Client #8] to be removed from the home. Both parties indicated they would not return their daughters until she was gone...."</p> <p>-On 3/24/14, "[Discharged Client #8] initiated aggression with peers. Staff intervened appropriately. Families arrived demanding that the police arrest [Discharged Client #8] or take her to Stress Center. Police did not agree with this and declined. Families indicated that they were going to take their children home to their houses and they would not bring them back until [Discharged Client #8] was gone. Waiver referral was submitted. Request for alternate group home referral was submitted. Prior to this incident there were 2 prior incidents on 2/5/14 and 3/19/14 in which physical restraint was implemented to restrain [Discharged Client #8] from harm to</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G076		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/17/2014	
NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 515 S 10TH ST NOBLESVILLE, IN 46060			
(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			
W000157	<p>others."</p> <p>On 10/17/14 at 10:03am, an interview was conducted with the facility's Group Home Manager/Qualified Intellectual Disabilities Professional (GHM/QIDP). The GHM/QIDP indicated the facility followed the BDDS reporting policy and procedure. The GHM/QIDP indicated the facility did not report Discharged Client #8's continued verbal and physical aggressive behaviors between Discharged client #8 and the staff or the verbal aggression between Discharged Client #8 and clients #2 and #6. The GHM/QIDP indicated the facility did not report when client #2 and #6's families did not return the clients to the facility because of Discharged Client #8's behaviors. The GHM/QIDP stated "it was a significant event" and "probably" should have been reported. The GHM/QIDP stated Discharged Client #8 "always" was physical with the facility staff and was "beginning to target" clients #2 and #6 for verbal and physical aggression.</p> <p>9-3-1(b)(5) 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.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G076		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/17/2014	
NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 515 S 10TH ST NOBLESVILLE, IN 46060			
(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>Based on record review and interview, for 1 of 2 allegations reviewed (for clients #2, #6, and Discharged Client #8), the facility failed to ensure corrective measures were implemented to protect clients #2 and #6 from Discharged client #8's behaviors of verbal and physical aggression resulting in the families removing their clients.</p> <p>Findings include:</p> <p>On 10/6/14 at 8:00pm and on 10/7/14 at 10:20am, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed from 10/1/13 through 10/06/14. The review indicated the following aggression by Discharged Client #8 toward clients #2 and #6.</p> <p>-An 3/25/14 BDDS report for an incident on 3/24/14 at 3:45pm, indicated a "[Client #6] was returning to her room after taking a shower. [Discharged Client #8] was in her room at the time, while [client #6] was starting to open her door, [Discharged Client #8] came out of her room and yelled at [client #6] Why are you looking at me Expletive. Staff ran upstairs and got in front of [Discharged Client #8] to block her from [client #6]... [Client #6] went into her room while staff was with [Discharged Client #8]." The</p>	W000157	<p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice?</i></p> <p>As mentioned, Client #8 and Client #2, #6 have been separated, as Client #8 has moved to a waiver setting according to her choices. Client #2 and #6 have had no further contact or concern with Client #8 other than voicing that they miss her. There were several revisions and retrainings, as well as onsite TL, Behavior Consultant and QIDP support. Documentation of these interventions were not able to be produced at survey.</p> <p><i>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 further incidents of peer to peer aggression will be reviewed with staff and retraining of BSPs will occur at that time. When any concerning or continuing aggression is noted, needed revisions to BSP support will be integrated into the BSP and implemented, given consents, within 24 hrs.</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>	11/16/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G076	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 515 S 10TH ST NOBLESVILLE, IN 46060
---	---

(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>report indicated client #6's roommate (client #2) who exited their shared bedroom to wash her hands in the bathroom while Discharged Client #8 continued to have behaviors. The report indicated Discharged Client #8 "continued" to be "involved in verbal aggression" and clients were in their rooms. Staff told client #2 "when she was done washing hands to come that they would go downstairs as it was her night to cook. Staff turned to go downstairs with [client #2], before [client #2] could fully get out of bathroom [Discharged Client #8] flew out of her room into the bathroom screaming and hit [client #2] across chest, [client #2] hit [Discharged Client #8] across chest" before staff could step between the clients. The report indicated Discharged Client #8 "continued" the verbal aggression for "approximately 10 minutes." The report indicated "both [clients #2 and #6] involved called family members after [Discharged Client #8] went to her room. One of the family members called the Police. The police came to the group home. The families arrived at the group home a little while later...Both [clients #2 and #6] went home with their parents for the rest of the evening and overnight...."</p> <p>On 10/7/14 at 10:20am, a review was</p>		<p><i>to ensure the deficient practice will not recur; what quality assurance program will be put into place?</i></p> <p>Group Home Manager/QIDP will monitor all Behavior Support plans and track all peer to peer aggression to ensure that no continued trend develops.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G076	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 515 S 10TH ST NOBLESVILLE, IN 46060
---	---

(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>conducted of Discharged Client #8's 4/16/14 narrative listing of events documented by the GHM/QIDP (Group Home Manager/Qualified Intellectual Disabilities Professional) indicated the following:</p> <p>-On 4/16/14, Discharged Client #8 moved out of the group home.</p> <p>-On 4/9/14, Client #2's parent "called asking about current progress" for Discharged Client #8 to be moved from the group home. Client #2's parent stated to the GHM/QIDP "that she was very disappointed in NHI (New Hope Indiana) response to this. That something should have been done a long time ago and faster but that administration and the power that be can pick and choose what they want to have happen. [Client #2's parent] indicated she had already spoken with the home and made arrangements for her daughter to return Sunday, 4/13/14."</p> <p>-On 4/7/14, Client #6's parent "called [GHM/QIDP] to inform me that her daughter (client #6) would be returning to the group home this evening after [Workshop]. She said she didn't want this to change anything about [Discharged Client #8] moving. [GHM/QIDP] informed her that it was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G076		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/17/2014	
NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 515 S 10TH ST NOBLESVILLE, IN 46060			
(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>[Discharged Client #8's] desire to move and NH is supporting her in that transition. Her daughter returning to the home would have no impact on changing that."</p> <p>-On 4/1/14, Client #6's parent was called "to discuss continued plans. Informed her that the funding was approved but that [Discharged Client #8] remained in her home until further notice. She indicated that she would keep her daughter home."</p> <p>-On 4/1/14, Client #2's parent was contacted by the GHM/QIDP "Informed her of same information. She elected to keep her daughter at her home."</p> <p>-On 3/28/14, a meeting with client #2's parent, client #6's parents, the BDDS Coordinator, and the GHM/QIDP was held "to discuss their concerns with the group home and the options they have. The meeting was held at their request based on their choice to take their children home until [Discharged Client #8] is moved from the home...Each family spent time verbalizing their concerns with the situation. They indicated that they see [Discharged Client #8] as violent, crazy, and in need of psychiatric hospitalization. They indicated that they do not feel that their</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G076	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 515 S 10TH ST NOBLESVILLE, IN 46060
---	---

(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>children are protected and want [Discharged Client #8] removed from the home."</p> <p>-On 3/28/14, received notice that Discharged Client #8's waiver placement was approved by BDDS.</p> <p>-On 3/25/14, GHM/QIDP "spoke with both parents regarding incident and their thoughts for resolution. Most frequently indicated were the desire for [Discharged Client #8] to be removed from the home. Both parties indicated they would not return their daughters until she was gone...."</p> <p>-On 3/24/14, "[Discharged Client #8] initiated aggression with peers. Staff intervened appropriately. Families arrived demanding that the police arrest [Discharged Client #8] or take her to Stress Center. Police did not agree with this and declined. Families indicated that they were going to take their children home to their houses and they would not bring them back until [Discharged Client #8] was gone. Waiver referral was submitted. Request for alternate group home referral was submitted. Prior to this incident there were 2 prior incidents on 2/5/14 and 3/19/14 in which physical restraint was implemented to restrain [Discharged Client #8] from harm to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G076	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 515 S 10TH ST NOBLESVILLE, IN 46060
---	---

(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>others."</p> <p>On 10/17/14 at 10:03am, an interview was conducted with the facility's Group Home Manager/Qualified Intellectual Disabilities Professional (GHM/QIDP). The GHM/QIDP indicated Discharged Client #8's continued verbal and physical aggressive behaviors between Discharged client #8 and the staff and the verbal aggression between Discharged Client #8 and clients #2 and #6. The GHM/QIDP indicated this resulted in client #2 and #6's families taking the clients home did not return the clients to the facility because of Discharged Client #8's behaviors. The GHM/QIDP stated "it was a significant event" and indicated the facility set up meetings between the families and the BDDS Coordinator. The GHM/QIDP indicated the facility had a Behavior Plan in place for Discharged Client #8's behaviors and the staff implement the plan. The GHM/QIDP indicated Discharged Client #8's Behavior Plan was to have prevented the behaviors of physical and verbal aggression but did not. The GHM/QIDP stated Discharged Client #8 "always" was physical with the facility staff and was "beginning to target" clients #2 and #6 for verbal and physical aggression. The GHM/QIDP indicated the facility staff were not retrained on Discharged Client</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G076	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 515 S 10TH ST NOBLESVILLE, IN 46060
---	---

(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
--------------------	--	---------------	---	----------------------

W000312	<p>#8's plans and no revisions to the plan was available for review.</p> <p>9-3-2(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 reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on interview and record review for 1 of 3 sampled clients with behavior controlling medications (client #1), the facility failed to have an active treatment program for the use of Melatonin which was being used for client to sleep, and which included a plan of reduction based on the behaviors for which the client was prescribed the medication for.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 10/8/14 at 12:05pm. Client #1's 9/24/14 physician's orders indicated client #1 received Melatonin 5mg (milligrams), give 1 tablet at bedtime started on "8/6/2014" and prescribed by client #1's psychiatrist for behaviors.</p> <p>Client #1's 2014 Behavioral Support Plan (BSP) did not indicate client #1's</p>	W000312	<p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice?</i></p> <p>Client #1 BSP was revised, medication addendum created, to address the use of Melatonin. Verbal consent was received by 11/7/14.</p> <p><i>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 other BSPs were reviewed by GH Director to have appropriate medication oversight, reduction plans and consents. Behavior consultants will review this issue as Melatonin is a supplement and not always noticed as historically psychotropic meds have been. Melatonin will be integrated into all</p>	11/16/2014
---------	---	---------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G076		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/17/2014	
NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 515 S 10TH ST NOBLESVILLE, IN 46060			
(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			
W000368	<p>Melatonin use. Client #1's 2014 BSP did not indicate client #1 had an active treatment program for the use of the Melatonin for sleep or a plan of reduction based on the behaviors for which the medication was prescribed.</p> <p>Interview with the Group Home Manager/Qualified Intellectual Disabilities Professional (GHM/QIDP) on 10/17/14 at 10:03am, indicated client #1 had Melatonin medication prescribed for sleep. The GHM/QIDP indicated client #1's BSP did not include an active treatment program for which client #1 received the Melatonin medication.</p> <p>9-3-5(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 4 of 8 clients (clients #2, #3, #5, and #7), the facility failed to administer medications without error and as prescribed by the clients' physician.</p> <p>Findings include: On 10/6/14 at 8:00pm and on 10/7/14 at 10:20am, the facility's BDDS (Bureau of</p>	W000368	<p>BSPs.</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 QIDPs will review BSPs for inclusion of all appropriate medications. Group Home Director will continue to conduct routine behavior plan audits, one facility per month. This resident was a new admission, so the prior audit completed did not include her BSP.</p> <p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice?</i></p> <p>Staff and nursing were retrained on the starting procedures for new medications. All staff have received numerous training regarding medication administration. NHI had previously changed to a multi-dose</p>	11/16/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G076	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 515 S 10TH ST NOBLESVILLE, IN 46060
---	---

(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>Developmental Disabilities Services) reports from 10/1/13 through 10/6/14 were reviewed and indicated the following for client #2, #3, #5, and #7's medication errors:</p> <p>For client #2: -An 6/30/14 BDDS report for an incident on 6/27/14 at 8:00am, indicated client #2 did not receive "her Septra DS antibiotic." The report indicated "There was a confusion due to the holding of one antibiotic and the starting of a 10 day antibiotic. Staff did not write when to start medication on MARs (Medication Administration Record)."</p> <p>For client #3: -An 7/22/14 BDDS report for an incident on 7/22/14 at 11:00am, indicated client #3's "PRN (As Needed medication) given as prescribed by doctor prior to dental appt. (appointment) PRN Valium 10mg (milligrams) (for anxiety), is to be given at bedtime the night prior to dental appt. and one hour before appt. scheduled." -An 6/6/14 BDDS report for an incident on 6/5/14 at 8:00pm, indicated for client #3 "On 6/5/14 [GHS (Group Home Staff) #2] administered 2 tabs of Lorazepam (for seizures) 1mg each to total 2mg. Order written was to administer 1 tab of Lorazepam 1mg for a total of 1mg." -An 5/23/14 BDDS report for an incident</p>		<p>packaging system which has dramatically decreased incidents of medication errors. Regardless, further oversight to improve this facility's administration record will continue. An additional retraining of all staff will occur week of 11/10/14.</p> <p><i>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? 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>Each shift will check institute a check system in which a second staff will double check that all medications were administered accurately. The Team Leader and Lead Direct Support staff will check the controlled substance sheets daily for one month, then weekly to ensure controlled medications were administered accurately. Medication regimens will be reviewed by the nurse consultant to identify any improvements to dosage times, to further decrease potential for error.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G076		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/17/2014	
NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 515 S 10TH ST NOBLESVILLE, IN 46060			
(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>on 5/21/14 at 4:00pm, indicated client #3 "did not receive her 4pm Clonazepam (for seizures) medication on 5/21/14. Medication was signed off on the MAR but medication was not removed from the bubble pack." -An 11/18/13 BDDS report for an incident on 11/16/13 at 8:00pm, indicated client #3 "received only one Lorazepam (for behavior) 0.5mg instead of the correct order of two Lorazepam 0.5mg on 11/16/13."</p> <p>Client #3's record was reviewed on 10/8/14 at 10:35am. Client #3's 10/2014 MAR (Medication Administration Record) and 7/2014 "Physician's Order" both indicated the medications of PRN Valium 10mg for anxiety, 1 tab at bedtime the night prior to dental appt. and one hour before appt. scheduled, Lorazepam 0.5mg give 2 tabs every night at bedtime for seizures, Lorazepam 0.5mg, give one half tablet twice daily for seizures, and Clonazepam for seizures.</p> <p>For client #5: -An 6/27/14 BDDS report for an incident on 6/26/14 at 8:00pm, indicated client #5 "did not receive her last packet of 3 of 3 medications packaged by the pharmacy. The medications include: Ziprasidone 60mg (for psychotic disorder), Ziprasidone (for psychotic disorder)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G076	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 515 S 10TH ST NOBLESVILLE, IN 46060
---	---

(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>40mg, and Trazodone HCL (for behaviors) 50mg."</p> <p>Client #5's record was reviewed on 10/8/14 at 11:00am. Client #5's 10/2014 MAR (Medication Administration Record) and 7/2014 "Physician's Order" both indicated the medications of "Ziprasidone 60mg (for psychotic disorder), Ziprasidone (for psychotic disorder) 40mg, and Trazodone HCL (for behaviors) 50mg."</p> <p>For client #7: -An 8/30/14 BDDS report for an incident on 8/29/14 at 8:00pm, indicated client #7's "Gabapentin (for behaviors) was recently increased from 100mg to 400mg. The pharmacy sent extra packs to make up required dosage. [Staff] only passed the 100mg and failed to administer the extra 300mg." -An 1/4/14 BDDS report for an incident on 1/3/14 at 4:00pm, indicated client #7 "did not receive her 4pm dose of Gabapentin 300mg."</p> <p>Client #7's record was reviewed on 10/8/14 at 11:00am. Client #7's 10/2014 MAR (Medication Administration Record) and 7/2014 "Physician's Order" both indicated the morning medications of Gabapentin 400mg 1 capsule 3 times a day for mood disorder.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G076		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/17/2014	
NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 515 S 10TH ST NOBLESVILLE, IN 46060			
(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>On 10/17/14 at 10:03am, an interview with the GHM/QIDP (Group Home Manager/Qualified Intellectual Disabilities Professional) was conducted. The GHM/QIDP indicated staff should administer medications according to physician's orders. The GHM/QIDP indicated staff did not follow the medication administration policy and procedure when medications were not administered according to physician's orders for clients #2, #3, #5, and #7.</p> <p>9-3-6(a)</p>						