

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G467	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3538 JULIE LN INDIANAPOLIS, IN 46208
--	--

(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 000 Bldg. 00	<p>This visit was for a recertification and state licensure survey.</p> <p>Survey dates: 3/17, 3/19 and 3/20/15.</p> <p>Facility Number: 000981 Provider Number: 15G467 AIMS Number: 100249390</p> <p>Surveyor: Paula Eastmond, QIDP-TC</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed March 23, 2015 by Dotty Walton, QIDP.</p>	W 000		
W 154 Bldg. 00	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on interview and record review for 1 of 2 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to conduct a thorough investigation in regard to client #2's injury of unknown source.</p>	W 154	<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>	04/19/2015

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: 15G467	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2015
NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3538 JULIE LN INDIANAPOLIS, IN 46208		
(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>Findings include:</p> <p>The facility's reportable incidents, facility incident reports (General Event Reports-GERs) and/or investigations indicated on 2/1/15 "Staff was assisting [client #2] for her AM (morning) hygiene. Then he noticed the bruise on her upper arm right." The facility's 2/1/15 GER indicated "...Injury Cause: Undetermined." The GER indicated the bruise was red in color. The 2/1/15 GER indicated the bruise was about 1.5 inches.</p> <p>The facility's reportable incident reports and/or investigations from 10/14 to 3/15 indicated the facility did not conduct an investigation in regard to client #2's above mentioned injury of unknown source.</p> <p>Interview with administrative staff #1 and the Team Leader (TL) on 3/19/15 at 3:05 PM indicated the TL interviewed staff in regard to the client's injury. The TL and/or administrative staff #1 indicated there was no documented investigation of client #2's injury of unknown source.</p> <p>9-3-2(a)</p>		<p><i>corrective action will be taken?</i></p> <p>New Hope of Indiana recently began utilizing an electronic system to generate internal incident reports (1/1/15). This incident occurred one month into implementation, leadership has since continued to fine tune this process and ensure thorough information is included. The injury noted had been identified as a minor bruise and an internal investigation was completed. The information had not properly been uploaded into the electronic system, but is now present.</p> <p>All other reports for the facility were reviewed during survey and had no other findings of deficiency. All other incidents since exit have also been reviewed on 4/10/15 for thorough completion.</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 Leaders and Managers reviewed this deficiency and the process to thoroughly conclude internal investigations, as well as continue to conduct full investigations when indicated.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G467	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3538 JULIE LN INDIANAPOLIS, IN 46208
--	--

(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 215 Bldg. 00	<p>483.440(c)(3)(iv) INDIVIDUAL PROGRAM PLAN</p> <p>The comprehensive functional assessment must identify the client's needs for services without regard to the actual availability of the services needed.</p> <p>Based on observation, interview and record review for 1 of 4 sampled clients (#1), the facility failed to obtain a speech assessment which included recommendations for training to increase the client's ability to communicate with</p>	W 215	<p>Director continues to see every event report generated and comment as needed on reportable status, follow up needed and approval/completion status. Director will continue to review all incidents immediately upon notification and at the completion of the investigation. Director will complete a monthly report of all incidents to analyze trends and proper completion of investigation and recommendations. Report will be conducted on the 2nd Friday of every month and maintained in Director's records.</p> <p>In addition, with recent electronic implementation, the data and reporting review has been much more easily accessible. With the improved data, New Hope of Indiana Quality Assurance department will be generating a quarterly report of all incidents to address trends and improvements globally.</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</i></p>	04/19/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G467	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3538 JULIE LN INDIANAPOLIS, IN 46208
--	--

(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>Findings include:</p> <p>During the 3/17/15 observation period between 4:20 PM and 6:23 PM and the 3/19/15 observation period between 6:10 AM and 8:15 AM, at the group home, client #1 was non-verbal in communication in that the client did not speak. During the above mentioned observation periods, staff #1, #2, #3, #4, #5 and/or #6 did not provide any communication training with the client.</p> <p>Client #1's record was reviewed on 3/19/15 at 11:46 AM. Client #1's 2/9/15 Individual Support Plan (ISP) indicated client #1 had a communication objective to choose pants to wear when given choices.</p> <p>Client #1's 11/14/14 Medical Appointment/New Order form indicated client #1 had a speech evaluation completed on 11/14/14. The form indicated "Pt (patient) seen today for evaluation of speech-language and swallowing. Recommend continue current diet with free water protocol. Pt may benefit from volume control cups (5 ml) (milliliters) (for water only). No speech therapy is recommended." Client #1's 11/14/14 speech evaluation did not</p>		<p><i>corrective action will be taken?</i></p> <p>Client #1 has a repeat speech and language evaluation scheduled for 4/13/15. Upon receipt of this report, recommendations will be reviewed by IDT and integrated into ISP.</p> <p>All other resident records will be reviewed to ensure appropriate speech, language and communication recommendations are present and implemented in ISPs, as appropriate.</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 will monitor pending and current communication goals for all residents. Review of documentation will occur to ensure proper implementation and success of communication plans for all individuals. Review will occur monthly upon review of monthly progress summary.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G467	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3538 JULIE LN INDIANAPOLIS, IN 46208
--	--

(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 249 Bldg. 00	<p>include any recommendations for training to assist the non-verbal client to increase his communication skills.</p> <p>Interview with staff #4 on 3/19/15 at 7:36 AM stated client #1 communicated his wants and needs by "banging on the table if he was not happy." Staff #4 also stated client #1 would "say a few words" and/or point to something he wanted.</p> <p>Interview with administrative staff #1 and the Team Leader (TL) on 3/19/15 at 3:05 PM stated client #1 had "limited verbal communication." Administrative staff #1 stated facility staff were to encourage the client to use "eye gaze" to communicate with others. The TL indicated client #1's communication objective was to choose the pants he wanted to wear with an eye gaze. The TL and administrative staff #1 indicated client #1's 11/14/14 speech evaluation did not include any recommendations for training to assist client #1 to communicate his wants and needs.</p> <p>9-3-4(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G467	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3538 JULIE LN INDIANAPOLIS, IN 46208
--	--

(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>each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, interview and record review for 1 of 4 sampled clients (#1) and for 1 additional client (#6), the facility failed to implement the clients' Individual Support Plan (ISP) objectives when formal and/or informal opportunities of training existed.</p> <p>Findings include:</p> <p>1. During the 3/17/15 observation period between 4:20 PM and 6:23 PM, at the group home, client #1 sat in his wheelchair with his head bent forward and eyes closed and/or sat at the dining room table without an activity and/or training. During the 3/17/15 observation period, staff #2 fed the client his dinner meal. Staff #2 did not encourage client #1 to feed himself.</p> <p>During the 3/19/15 observation period between 6:10 AM and 8:15 AM, at the group home, client #1 came out of his bedroom dressed for the day at 6:30 AM. Client #1 was fed his breakfast and then returned to his bedroom to sit in front of his TV. Client #1 made loud sounds and yelled out while he was in his bedroom.</p>	W 249	<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>Group Home direct care staff will be retrained on all program goals and implementation expectations. All goals are in the electronic documentation system and able to be reviewed by QIDP daily.</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>Group Home QIPD will review goal implementation daily for 1 week, then weekly for 30 days to ensure that implementation and documentation is properly improved.</p> <p>In addition to documentation review</p>	04/19/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G467	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3538 JULIE LN INDIANAPOLIS, IN 46208
--	--

(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>Staff #4, #5 and #6 did not offer the client a more meaningful activity for participation, and/or provide any training with the client.</p> <p>Client #1's record was reviewed on 3/19/15 at 11:46 AM. Client #1's 2/9/15 ISP indicated the client had objectives to make a craft with hand over hand assistance, to call his father and an objective to point to a nickel versus a crayon which facility staff did not implement when formal and/or informal training opportunities existed.</p> <p>Client #1's 1/1/15 Dining Plan indicated client #1 required "Direct 1:1 (one staff to one client) supervision when the client ate his meals. Client #1's 1/1/15 Dining Plan and/or 2/9/15 ISP did not indicate client #1 was to be fed by facility staff.</p> <p>Interview with the Team Leader (TL) and administrative staff #1 on 3/19/15 at 3:05 PM indicated client #1's ISP objectives should be implemented when opportunities existed. The TL indicated facility staff should encourage client #1 to initiate feeding himself and then assist the client to eat when he stopped/refused. Administrative staff #1 stated client #1 was "hard to engage in training."</p> <p>2. During the 3/19/15 observation period</p>		<p>for completion, Group Home QIDP will observe that proper activities and training are offered to Client #1. Biweekly on site observations will be conducted to ensure that all other residents are offered appropriate activities and training during formal and informal opportunities, including but not limited to medication administration, dining, meal preparation, leisure skills and community involvement. These observations will occur for 2 weeks, addressing any noted concerns at time of visit. QIDP will then resume weekly onsite observations. Nurse Consultant and QIDP will also conduct onsite observation of med pass and goals weekly for 3 weeks, then resume monthly med observations.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G467	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3538 JULIE LN INDIANAPOLIS, IN 46208
--	--

(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 312 Bldg. 00	<p>between 6:10 AM and 8:15 AM, at the group home, client #6 received a calcium vitamin supplement, blood pressure medication and an allergy pill at the morning medication pass. Staff #4 did not provide any medication training with the client.</p> <p>Client #6's record was reviewed on 3/19/15 at 3:00 PM. Client #6's 1/30/15 ISP indicated client #6 had an objective to state the morning medication time. Staff did not implement the client's medication training objective.</p> <p>Interview with the TL on 3/19/15 at 3:05 PM indicated client #6's medication training should be implemented at the medication pass.</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 reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on interview and record review for 1 of 2 sampled clients (#4) who received behavior controlling medications, the facility failed to ensure an active</p>	W 312	<p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice? How will other</i></p>	04/19/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G467	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3538 JULIE LN INDIANAPOLIS, IN 46208
--	--

(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>treatment program was developed for the use of a bedtime medication used to assist the client to sleep.</p> <p>Findings include:</p> <p>Client #4's record was reviewed on 3/19/15 at 1:22 PM. Client #4's March 2015 physician's orders indicated client #4 received Melatonin 3 milligrams at night for "sleep aid."</p> <p>Client #4's 2/1/15 Behavior Support Plan (BSP) indicated client #4 demonstrated the behaviors of refusing to participate/isolating himself in his room, "high levels of anxiety" and wandering off. Client #4's BSP indicated Melatonin was part of the client's BSP. Client #4's BSP indicated "...Medication History: Ambien and Trazadone (sic) were started separately in 2012 to help [client #4] sleep at night, but neither appeared to work. Trazadone (sic) caused him to become more anxious than usual. Melatonin has had the best results...."</p> <p>Client #4's 2/1/15 BSP indicated client #4's diagnosis included, but was not limited to, Schizophrenia. Client #4's 2/1/15 BSP did not indicate the facility was monitoring/tracking the client's sleep patterns. Client #4's BSP did not indicate the client had an active treatment program for the use of the Melatonin.</p>		<p><i>residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?</i></p> <p>The Behavior Support Plan tracking was updated to include data collection regarding Client #4 sleep patterns relevant to use of Melatonin. The Behavior plan includes an active treatment element for the use of the medication.</p> <p>All other plans have been reviewed ensuring that all medication uses are properly addressed with a corresponding active treatment plan and data tracking.</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 has completed an audit of all BSPs for all facilities. Director has audit with targeted behaviors and other requirements on audit and reviews audit monthly for updates.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G467	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3538 JULIE LN INDIANAPOLIS, IN 46208
--	--

(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 488 Bldg. 00	<p>Interview with administrative staff #1 and the Team Leader on 3/19/15 at 3:05 PM indicated client #4 received the Melatonin to assist the client to sleep at night. The TL and administrative staff #4 indicated the facility did not monitor/track client #4's sleep. The TL and administrative staff #1 indicated client #4's BSP did not address the client's sleeplessness at night.</p> <p>9-3-5(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 and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) and for 4 additional clients (#5, #6, #7 and #8), the facility failed to ensure the clients participated in preparing their own lunch/putting food in containers, and/or packing their own lunch.</p> <p>Findings include:</p> <p>During the 3/19/15 observation period between 6:10 AM and 8:15 AM, at the group home, staff #5 placed tuna casserole and broccoli into plastic containers for clients #1,</p>	W 488	<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 all dining plans and meal preparation, participation and services.</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</i></p>	04/19/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G467	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3538 JULIE LN INDIANAPOLIS, IN 46208
--	--

(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>#2, #3, #4, #5, #6, #7 and #8's lunches. Clients #2, #3, #4 #5 and #7 sat in the dining room, at the table, while the staff placed the food into the containers. Staff #5 did not involve the clients. Staff #5 verbally prompted clients #3 and #4 to place their containers and other food items into their individual lunch bags. Staff #4 packed/placed the containers and/other food items into clients #1, #2, #5, #6, #7 and #8's lunch bags without involving the clients.</p> <p>Interview with administrative staff #1 and the Team Leader (TL) on 3/19/15 at 3:05 PM indicated clients #1, #2, #3, #4, #5, #6, #7 and #8 should be involved in fixing and/or packing their own lunches.</p> <p>9-3-8(a)</p>		<p><i>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>Biweekly on site observations will be conducted to ensure that all other residents are offered appropriate activities and training during formal and informal opportunities, including but not limited to medication administration, dining, meal preparation, leisure skills and community involvement.</p>	