

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G487	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/20/2014
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NAME OF PROVIDER OR SUPPLIER  NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4822 ALAMEDA ST INDIANAPOLIS, IN 46208
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W000000	<p>This visit was for a fundamental recertification survey and state licensure survey.</p> <p>Dates of Survey: June 18, 19 and 20, 2014.</p> <p>Facility Number: 001001 AIMS Number: 100245000 Provider Number: 15G487</p> <p>Surveyor: Susan Reichert, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/27/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation and interview, the facility failed to provide unimpeded access to the home's thermostat to</p>	W000125	<p><i>What corrective actions will be accomplished for these residents found to have been affected by this practice? The locked cover</i></p>	06/23/2014

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.

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	<p>regulate temperature for 5 of 6 clients (clients #1, #2, #3, #4, and #8), and failed to develop a plan to regain access to the thermostat for (clients #5, #6 and #7).</p> <p>Findings include:</p> <p>Observations were completed at the group home where clients #1, #2, #3, #4, #5, #6, #7 and #8 resided on 6/18/14 from 4:35 PM until 6:10 PM. The temperature in the medication room measured 82.8 degrees and the temperature in the dining room measured 82.6. Staff #6 and staff #4 had sweat rivulets on their faces. There was a locked thermostat in the hallway outside the medication administration room.</p> <p>Staff #4 and #6 were interviewed on 6/18/14 at 5:30 PM and stated, "It's very warm." Staff #4 indicated the thermostat was locked and stated, "We don't have access to it." Staff #6 indicated the thermostat was locked because client #7 would get up in the night and adjust the temperature.</p> <p>Staff #5 was interviewed on 6/19/14 at 8:00 AM and indicated the thermostat was locked because clients #5 and #7 would adjust the temperature inappropriately. He indicated the key was locked in the safe and none of the clients</p>		<p>that impeded access to the thermostat has been removed. Temperature has been set at 72-74 degrees and remains comfortable. Director was in the home on 7/1/14 and home temperature was within the 72-74 degree range and comfortable. <i>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</i> All staff and residents of the facility have access to the thermostat. Staff were trained on proper maintenance and temperature regulation of the home. All residents were assessed and none indicated a need for further training in regard to thermostat. <i>What measures will be put into place or what systematic changes the facility will make to ensure the deficient practice does not recur.</i> <i>How the corrective actions will be monitored.</i> Team Leader will monitor temperature regulation during daily visits to the home during the work week. Manager/QIDP will also continue to monitor temperature regulation to the home during her weekly visits to home. New Hope of Indiana will monitor temperature regulation of the home during monthly preventive maintenance trips to home.</p>	

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W000149	<p>had access to the key.</p> <p>The Director of Group Homes, Group Home Manager/QIDP (Qualified Intellectual Disabilities Professional) and Team Leader were interviewed on 6/19/14 at 2:00 PM and indicated the thermostat was locked as clients #5, #6 and #7 had a history of adjusting the temperature inappropriately. They indicated none of the clients in the home had a plan to regain access to the thermostat.</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on record review and interview, the facility neglected to implement policy and procedures to protect 1 of 4 sampled</p>	W000149	<p><i>What corrective actions will be accomplished for these residents found to have been affected by this practice?</i></p>	07/20/2014

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	<p>clients (client #1) from a bite by client #6, and failed to provide adequate supervision to address client #6's self injurious behavior to prevent injury.</p> <p>Findings include:</p> <p>The facility's incidents reported to the Bureau of Developmental Disabilities Services (BDDS) since 3/18/14 and BDDS reports with investigations from 6/18/13 were reviewed on 6/18/14 at 2:40 PM and included the following:</p> <p>1. A BDDS report dated 10/21/13 indicated "During the morning van run, [client #6] bit [client #1] on the top of his right ear. [Client #1] was transported to immediate care to treat injuries. Injuries were a small bite mark that broke the skin, but not requiring stitches. [Client #1's] injury was treated by immediate care by cleaning and bandaging and providing an antibiotic prescription. [Client #1] was offered Tylenol as needed for pain." Corrective action indicated client #6 "is to ride in the front seat of the van at all times...Staff will ride in the van when [client #6] is being transported, one driving and one additional staff in van seated with other individuals. A single staff will be assigned for direct supervision of [client #6] throughout the day...."</p>		<p>Since the 10/21/13 incident in which client #6 bit client #1 the safety plan for transportation has been followed and no further incidents involving these individuals have occurred. Additionally, client #1 has begun riding IndyGo public transportation independent from his peers to further mitigate further incidents.</p> <p>All staff were retrained on the behavior support plan specific to client #6 and his targeted behavior of self injury tendencies.</p> <p><i>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</i></p> <p>All staff were retrained on behavior support plans and transportation plans for all residents in the home.</p> <p><i>What measures will be put into place or what systematic changes the facility will make to ensure the deficient practice does not recur. How the corrective actions will be monitored.</i></p> <p>Facility will continue to follow the transportation and behavior support plans for all individuals. All incidents of abuse, neglect or exploitation will continue to be reported, investigated and resolved according the New Hope of Indiana policy and</p>	

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	<p>An attached investigation completed on 10/23/13 indicated "Staff indicated that [client #6] bit [client #1] as he was sitting behind [client #1]. Typically [client #6] does not ride the van on Mondays, but had a PT (physical therapy) appoint. Staff situated him behind [client #1] in error. [Client #6] could not indicate why he did this, nor could [client #1]. On all other days that [client #6] is transported, staff provide 2 staff on the vehicle to maintain safety...." Corrective action included, "Continue to provide 2 staff on all rides in which [client #6] is present...."</p> <p>2. A BDDS report dated 4/29/14 indicated client #6 "came to staff and showed them a scraped area on his leg that was in need of treatment. He told staff that he had scraped his leg with a pair of scissors, on Sunday (date unspecified) while sitting in the dining room. When interviewed he stated that staff were in the living room and helping someone else in another room when he scraped himself with the scissors. He has Self Injurious behavior (SIB) in his behavior plan. Staff are to monitor him when using sharps. After interviewing staff, peer (client #4) had scissors out when working on a craft project. [Client #6] got a hold of the scissors without staff knowledge." Corrective action</p>		<p>procedure. Behavior consultant will continue to monitor the monthly, or as needed, support to Client #6 to ensure support plan remains effective and staff are following plan effectively.</p>				

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	<p>indicated scissors are to be secured in the office, staff were to follow client #6's BSP (Behavior Support Plan) and "monitor that sharps are put up after peers use them. Also monitor [client #6] if he is in the room where sharps are being used by others. TL (Team Leader) to retrain staff regarding [client #6] and sharps safety."</p> <p>Client #6's BSP dated 9/1/13 was reviewed on 6/19/14 at 3:05 PM. The plan indicated target behaviors of physical aggression (striking others), and SIB (picking at scabs or scars, poking himself with thumb tacks, butter knives, etc., cutting his wrist with broken CDs (compact discs). Proactive interventions for SIB indicated "Due to [client #6's] history of self-injury, all knives sharper than a butter knife, at [group home] are to be kept locked." The plan indicated if client #6 engaged in physical aggression staff were to "intervene immediately by firmly telling him to stop," and "If [client #6] is being aggressive against a peer, step between the individuals if necessary to prevent further aggression...."</p> <p>A Functional Behavior Assessment included with the BSP dated 7/1/13 indicated client #6's "mood is usually pleasant, but he has a long history of</p>			

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	<p>maladaptive behaviors, including...physical aggression, self injurious behavior and inappropriate touching...."</p> <p>The Director of Group Homes, Group Home Manager/QIDP (Qualified Intellectual Disabilities Professional) and Team Leader were interviewed on 6/19/14 at 2:00 PM and indicated client #6 should have been supervised to prevent access to the scissors, and staff were unaware he had obtained scissors after client #4 got them out for a craft project.</p> <p>The Director of Group Homes was interviewed again on 6/20/14 at 9:58 AM and indicated client #6 was not supposed to be seated behind client #1 and it was a failure of normal procedures when he sat behind client #1 on 10/21/13.</p> <p>The facility's Policy on Suspected Abuse revised 1/2014 was reviewed on 6/19/14 at 3:05 PM and indicated "...Neglect is a practice than denies any of the following without a physician's order: the repeated failure of a caregiver to provide supervision...."</p> <p>9-3-2(a)</p>			

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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, 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 upon observation, interview and record review, the facility failed for 3 of 4 sampled clients (#1, #3 and #4) to implement their objectives to increase skills in self administration of medication.</p> <p>Findings include:</p> <p>Observations were completed in the group home on 6/18/14 from 4:35 PM until 6:10 PM. Client #4's blood sugar was taken by staff #6. Client #4 was redirected from taking the testing strip from the container by staff #6. Client #4 instructed staff #4 to pull the test strip out and restart the testing device when the</p>	W000249	<p><i>What corrective actions will be accomplished for these residents found to have been affected by this practice? How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All staff were retrained on the medication administration goals and opportunities for training for all residents of the facility. What measures will be put into place or what systematic changes the facility will make to ensure the deficient practice does not recur. How the corrective actions will be monitored. Team Leader and/or QIDP will observe medication goals being implemented appropriately on a weekly basis by direct observation of training and review of medication goal</i></p>	07/20/2014

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	<p>first attempt failed to obtain a reading. Client #4 then redirected staff #6 from re-sticking his finger a second time after showing staff #6 he was able to obtain another drop of blood from the first finger stick. Staff #6 then completed all steps of the blood sugar check and documented the results in the MAR (medication administration record). Client #4 was not prompted to complete the steps or document the check of his blood sugar level. Client #1 was given a vitamin at 5:25 PM by pouring the pill into his mouth from a paper envelope by staff #6. Client #1 opened his mouth to receive the medication, but was not prompted to administer his medications with physical assistance. Client #3 received Metoprolol (hypertension) 25 mg (milligrams) in applesauce during medication administration at 5:25 PM. Client #3 was not asked to identify why he took Metoprolol.</p> <p>The 6/14 MAR and self administration of medication objectives and documentation were reviewed on 6/18/14 at 5:50 PM and indicated the following:</p> <p>Client #4's 5/1/14 objective indicated "Staff will ask [client #4] to take his blood sugar, than record it on a data sheet in the evening." The objective indicated the objective was to be offered daily and</p>		data.	

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	<p>at informal opportunities.</p> <p>Client #1's 3/18/14 objective indicated he was to take his medication with physical assistance of hoh (hand over hand).</p> <p>Client #3's undated objective kept in the MAR indicated he was to identify the reason he took Metoprolol (blood pressure).</p> <p>Client #3's undated self administration of medication objective was reviewed on 6/20/14 at 2:30 PM indicated he was to identify the reason he took melatonin (sleep aid).</p> <p>The Director of Group Homes, Group Home Manager/QIDP (Qualified Intellectual Disabilities Professional) and Team Leader were interviewed on 6/19/14 at 2:00 PM and indicated the clients' plans should have been implemented.</p> <p>9-3-4(a)</p>			
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W000429	<p>483.470(e)(2)(i) HEATING AND VENTILATION The facility must maintain the temperature and humidity within a normal comfort range by heating, air conditioning or other means.</p> <p>Based on observation and interview, the facility failed to maintain the temperature at a normal comfort range for 4 of 4 sampled clients (clients #1, #2, #3 and #4) and for 4 additional clients (clients #5, #6, #7 and #8).</p> <p>Findings include:</p> <p>Observations were completed at the group home where clients #1, #2, #3, #4, #5, #6, #7 and #8 resided on 6/18/14 from 4:35 PM until 6:10 PM. The temperature in the medication room measured 82.8 degrees and the temperature in the dining room measured 82.6. Staff #6 and staff #4 had sweat rivulets on their faces. There was a locked thermostat in the hallway outside the medication administration room.</p> <p>Staff #4 and #6 were interviewed on 6/18/14 at 5:30 PM and stated, "It's very warm." Staff #4 indicated the thermostat was locked and stated "We don't have access to it."</p> <p>The Director of Group Homes, Group Home Manager/QIDP (Qualified</p>	W000429	<p>What corrective actions will be accomplished for these residents found to have been affected by this practice? The locked cover that impeded access to the thermostat has been removed. Facility Maintenance was in the home the following morning to ensure that air conditioning and ventilation were functioning properly. Temperature has been set at 72-74 degrees and remains comfortable. Director was in the home on 7/1/14 and home temperature was within the 72-74 degree range and comfortable. <i>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</i> All staff and residents of the facility have access to the thermostat. Staff were trained on proper maintenance and temperature regulation of the home. All residents were assessed and none indicated a need for further training in regard to thermostat. <i>What measures will be put into place or what systematic changes the facility will make to ensure the deficient practice does not recur.</i> <i>How the corrective actions will be monitored.</i> Team Leader will monitor temperature regulation during daily visits to the home</p>	06/23/2014
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W000433	<p>Intellectual Disabilities Professional) and Team Leader were interviewed on 6/19/14 at 2:00 PM and indicated the key to the thermometer was locked in the safe, and staff had access to the safe to adjust the temperature. They indicated the temperature of the home should not have been 82.8 degrees.</p> <p>9-3-7(a)</p> <p>483.470(f)(3) FLOORS The facility must have exposed floor surfaces and floor coverings that promote mobility in areas used by clients. Based upon observation, record review and interview, the facility failed for 3 of 4 sampled clients (clients #1, #2 and #3) and for 2 additional clients (clients #6 and #8) , the facility failed to maintain the group home floor in good condition</p>	W000433	<p>during the work week. Manager/QIDP will also continue to monitor temperature regulation to the home during her weekly visits to home. New Hope of Indiana will monitor temperature regulation of the home during monthly preventive maintenance trips to home.</p> <p>What corrective actions will be accomplished for these residents found to have been affected by this practice?The flooring for this area of the home is presently being assessed and will be replaced by the 7/20 correction</p>	07/20/2014

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	<p>to promote mobility for clients who used wheelchairs and had unstable gaits.</p> <p>Findings include:</p> <p>Observations were completed at the group home where clients #1, #2, #3, #4, #6 and #8 on 6/18/14 from 4:35 PM until 6:10 PM and again on 6/19/14 from 6:40 AM until 8:10 AM. There was a 3 inch by 2 inch depression 1/2 inch deep in the flooring in the hallway of the kitchen. There was a missing piece of flooring 6 inches by 2 inches in the center of the kitchen. Clients #1, #3 and #6 used wheelchairs for mobility. Client #2 had a gait belt and client #8 was blind and used a cane for mobility.</p> <p>Staff #5 was interviewed on 6/19/14 at 7:25 AM and indicated the depression in the flooring had occurred 6 months ago and new flooring was on order.</p> <p>Client #1's record was reviewed on 6/19/14 at 11:55 AM. His 8/13/13 Individual Support Plan (ISP) indicated he had a risk plan for falling.</p> <p>Client #2's record was reviewed on 6/19/14 at 1:25 PM. His 2/5/14 ISP indicated he had a risk plan for falling.</p> <p>Client #3's record was reviewed on</p>		<p>date. If there is a delay in this correction time due to contractor availability or otherwise, Director will contact ISDH with this information. <i>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</i> All other resident rooms and common living areas were assessed and one other resident room will have carpet replaced where a small seam tear has occurred. <i>What measures will be put into place or what systematic changes the facility will make to ensure the deficient practice does not recur.</i> How the corrective actions will be monitored. Manager and Director will continue to monitor the condition of flooring and environment on routine visits to home. Manager is in the home weekly. Director visits homes on a monthly basis.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G487	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/20/2014
NAME OF PROVIDER OR SUPPLIER  NEW HOPE OF INDIANA, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4822 ALAMEDA ST INDIANAPOLIS, IN 46208		
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	<p>6/19/14 at 12:25 PM. His ISP dated 7/29/14 indicated he had a risk plan for falling.</p> <p>The Director of Group Homes, Group Home Manager/QIDP (Qualified Intellectual Disabilities Professional) and Team Leader were interviewed on 6/19/14 at 2:00 PM and indicated maintenance had the repair/replacement of the flooring on their list of projects to complete, but it was not in process at this time.</p> <p>9-3-7(a)</p>				