

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/27/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE 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 0000 Bldg. 00	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of survey: 1-19-16, 1-20-16, 1-21-16 and 1-27-16.</p> <p>Facility Number: 000972 Provider Number: 15G458 AIMS Number: 100244840</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 2/1/16.</p>	W 0000		
W 0137 Bldg. 00	<p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>Based on observation, record review and interview for 1 of 4 sampled clients (#4), the facility failed to ensure client #4's ISP (Individual Support Plan) included training to teach client #4 how to utilize and care for her personal clothing.</p>	W 0137	<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>	02/10/2016

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: 15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/27/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE 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>Observations were conducted at the group home on 1/21/16 from 6:00 AM through 8:15 AM. At 6:25 AM, client #4 entered the medication administration office and requested her clothing for the day. Client #4's personal clothing was stored in plastic tote containers in the medication administration office.</p> <p>Staff #1 was interviewed on 1/21/16 at 6:25 AM. Staff #1 indicated client #4's clothing was kept in storage totes in the medication administration room. Staff #1 indicated client #4's clothing was kept in the medication administration room due to client #4's behaviors of frequently changing her clothing and throwing her clothing away in the trash.</p> <p>Client #4's record was reviewed on 1/20/16 at 1:40 PM. Client #4's ISP dated 7/2/15 did not indicate documentation of formal training or informal supports to assist client #4 acquire the skills necessary to care for and utilize her clothing.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 1/21/16 at 8:45 AM. QIDP #1 indicated client #4's clothing was kept in storage totes in the medication administration</p>		<p>Team implemented goal for Client #4 to make choices for her clothing. Goal was implemented 2/3/2016. No other rights violations for any other residents of the facility have been noted or found during post survey review.</p> <p>All staff were able to review goal and involvement for Client #4 at staff meeting on 2/10/2016.</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 and Team Leader have conducted observations in the home to ensure that the goal is being implemented and that involvement of client #4 is effective. Observations occurred for 5 business days after survey exit and will continue with ongoing observations in home 2-3 days per week.</p> <p>QIDP will also monitor goal progress during monthly case management reviews.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/27/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE 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 0242 Bldg. 00	<p>office due to client #4's behaviors of throwing her clothing away. QIDP #1 indicated client #4 did not have formal training or informal supports to assist her acquire skills necessary to care for or utilize her clothing.</p> <p>9-3-2(a)</p> <p>483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.</p> <p>Based on observation, record review and interview for 1 of 4 sampled clients (#2), the facility failed to ensure client #2's ISP (Individual Support Plan) included training in regard to recommended communication needs.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 1/19/16 from 4:51 PM through 6:00 PM and on 1/21/16 from 6:00 AM through 8:15 AM. Client #2 was observed at the group home</p>	W 0242	<p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice? How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?</i></p> <p>QIDP has implemented goal for communication for Client #2. Goal was implemented 2/4/2016. All other individuals were reviewed to have appropriate communication or goals as assessments indicated.</p>	02/10/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/27/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE 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>throughout the observation periods. Client #2 was non-verbal in that she did not use verbal communication to express her wants or needs. Client #2 did not utilize a picture board to assist her communicate her wants or needs. Client #2's picture board was hanging on a wall in the home's front room throughout the observation periods.</p> <p>Client #2's record was reviewed on 1/20/16 at 12:45 PM. Client #2's Speech Therapy Consultation (STC) form dated 11/19/15 indicated, "Create choice boards using photographs. Create schedule boards for situations through her day." Client #2's ISP dated 5/12/15 indicated client #2's diagnoses included, but were not limited to, Autism and Moderate Intellectual Disability. Client #2's ISP dated 5/12/15 indicated, "Communication, a. Will respond to 'it's bedtime' via eye gaze with verbal cues at 50%." Client #2's CFA (Comprehensive Functional Assessment) dated 5/12/15 indicated client #2 did not make eye contact during conversation, utilized crying, clapping, yelling and repetitively said the word "hello". Client #2's ISP dated 5/12/15 did not indicate documentation of a formal training objective or informal supports to teach client #2 how to utilize her picture board to communicate her wants and needs.</p>		<p>All staff were able to review goal for Client #2 at staff meeting on 2/10/2016.</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 and Team Leader have conducted observations in the home to ensure that the goal is being implemented and that involvement of client #2 is effective. Observations occurred for 5 business days after survey exit and will continue with ongoing observations in home 2-3 days per week.</p> <p>QIDP will also monitor goal progress during monthly case management reviews.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/27/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE 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 0247 Bldg. 00	<p>QIDP (Qualified Intellectual Disability Professional) #1 was interviewed on 1/21/16 at 8:50 AM. QIDP #1 indicated client #2 had a STC on 11/19/15. QIDP #1 indicated client #2's 11/19/15 STC recommendations included the use of a picture board to assist client #2 to communicate her wants or needs. QIDP #1 indicated client #2's picture board was hung on a wall in the home and staff working with client #2 should utilize her picture board to communicate.</p> <p>9-3-4(a)</p> <p>483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management.</p> <p>Based on observation, record review and interview for 2 of 4 sample clients (#2 and #3), plus 2 additional clients (#5 and #7), the facility failed to ensure clients #2, #3, #5 and #7 were provided the opportunity to choose/utilize their preferred condiments during meal time.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 1/19/16 from 4:45 PM</p>	W 0247	<p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice? How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?</i></p> <p>QIDP and Team Leader offered training to all DSPs on the options for complimenting the meal with seasonings and condiments and how this can be accomplished during the</p>	02/10/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/27/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE 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>through 6:00 PM. Client #5 participated in the home's family style meal which included green beans. At 5:20 PM client #5 stated, "These beans aren't hot enough." Staff #1, #2 and #3 who were seated at the table indicated the beans had already been seasoned while cooking. Client #5 was not offered salt, pepper, or other seasonings.</p> <p>Client #5 was interviewed on 1/19/16 at 5:40 PM. Client #5 indicated she would like her beans to be spicier.</p> <p>Staff #1 was interviewed on 1/19/16 at 5:43 PM. Staff #1 stated, "[Client #5] likes her green beans spicy, she likes to add cayenne pepper and spices to it." Staff #1 indicated there were not seasonings available on the table and client #5 was not offered seasonings for her meal.</p> <p>Observations were conducted at the group home on 1/21/16 from 6:00 AM to 8:30 AM. Clients #2, #3, #5, and #7 participated in the home's family style meal which included but was not limited to toast and cereal. Clients #2, #3, #5 and #7 were not offered a choice of jam or jelly for their toast.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on</p>		<p>family style dining. This training occurred 2/10/16 during routine staff meeting.</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 and Team Leader have conducted observations in the home to ensure that the meals continue to follow dining plans, menus and solicit choice and active treatment. Observations occurred for 5 business days after survey exit and will continue with ongoing observations in home 2-3 days per week.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/27/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE 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 0369 Bldg. 00	<p>1/21/16 at 8:45 AM. QIDP #1 indicated clients #2, #3, #5 and #7 should be offered a choice of condiments and seasonings with their meals.</p> <p>9-3-4(a)</p> <p>483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review and interview for 1 of 4 sampled clients (#3), the facility failed to ensure client #3's medication was administered without error.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 1/21/16 at 6:00 AM through 8:00 AM. At 6:55 AM, client #3 received his morning medications which included but was not limited to Advair Disc Inhaler (Congestive Heart Failure). Client #3 received 1 puff of the inhaler and then was not prompted/encouraged to rinse his mouth after using the inhaler.</p> <p>Client #3's Advair Disc Inhaler pharmacy label was reviewed on 1/21/16 at 7:00</p>	W 0369	<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>Inhaler protocol was developed to support order and proper administration and post administration practices. Client #3 is unable to swish and spit after inhaler so team developed a plan to use mouth swabs in the practice of rinsing his mouth after inhaler treatment.</p> <p>All other individuals received medications without error. No other individuals utilize an inhaler or other</p>	02/10/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/27/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE 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>AM. Client #3's Advair Disc Inhaler pharmacy label indicated, "Inhale 1 puff orally every 12 hours. Rinse mouth after every use."</p> <p>Client #3's record was reviewed on 1/20/16 at 11:17 AM. Client #3's Physician's Orders form dated 12/8/15 indicated, "Advair Disc Aerosol. Inhale 1 puff orally every 12 hours. Diagnosis: Congestive Heart Failure. Rinse mouth after every use."</p> <p>LPN (Licensed Practical Nurse) #1 was interviewed via telephone on 1/21/16 at 9:06 AM. LPN #1 indicated medication should be administered as ordered by the physician.</p> <p>9-3-6(a)</p>		<p>device requiring specified protocols.</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 and Team Leader have conducted observations in the home to ensure that medications are being administered without error. Observations occurred for 5 business days after survey exit and will continue with ongoing observations in home 2-3 days per week.</p> <p>Nurse consultant will also have daily access to electronic medication administration record to view that tasks related to proper medication administration are completed and documented.</p>	