

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 12/27/2013
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NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3538 JULIE LN INDIANAPOLIS, IN 46208
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W000000	This visit was for an annual fundamental recertification and state licensure survey. Survey Dates: December 16, 18, 19 and 27, 2013. Facility Number: 000981 Provider Number: 15G467 AIMS Number: 100249390 Surveyors: Vickie Kolb, RN These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review completed January 6, 2014 by Dotty Walton, QIDP.	W000000		
W000104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview and record review for 4 of 4 sampled clients (#1, #2, #3 and #4) and 4 additional clients (#5, #6, #7 and #8), the facility's governing body failed to exercise general policy and operating direction over the facility to ensure: ___ All client to client abuse and all injuries of unknown origin were thoroughly investigated for clients #5,	W000104	What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice?The governing body will review all investigations to note all required interviews are present. As noted in the survey interview, prior implementation of our procedure included gathering all relevant interviews as deemed appropriate by the person conducting the investigation, generally the QIDP.	01/24/2014

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>#6 and #8.</p> <p>___Nursing services developed and implemented a specific plan of care to indicate how the staff were to monitor client #1's diet, food intake, weight and blood pressure in regard to client #1's history of excess weight/obesity, hypertension, low potassium levels and refusals to comply with medical monitoring.</p> <p>___The staff notified nursing services when not able to identify the dosage of a medication on the medication packet provided by the pharmacist and when medication labels were incorrectly labeled for clients #2, #4, #6 and #8.</p> <p>___The staff followed the facility's medication policy in giving the medications during the indicated windows of medication times for clients #3, #4, #5, #6 and #7.</p> <p>Findings include:</p> <p>1. Please see W149. The governing body failed to exercise general policy and operating direction over the facility to ensure all client to client abuse and all injuries of unknown origin were thoroughly investigated for clients #5, #6 and #8.</p> <p>2. Please see W154. The governing body failed to exercise general policy and</p>		<p>For incidents in which a client to client altercation was directly observed in its entirety (2 of the 3 incidents), it was not indicated as necessary to gather interviews from all parties, unless the investigation went in a direction that more information or perspective was needed. Going forward, all investigations will include interviews from all parties present, including the statement from the original staff observing the event and any other individuals or staff present/relevant to the investigation. In addition, all incidents that occur at Day Services will be directed by the residential home manager instead of the New Hope of Indiana Day Services. All injuries of unknown origin will include interviews with all staff. The investigation noted had those interviews, however, they were not maintained in the investigation folder at that time. They are now present in that investigation. Governing Body will ensure that High Risk Plans are updated to include client specific guidance on vital sign parameters (blood pressure, heart rate, etc). Director will review that all current weights are present. Director will train all leadership and nursing staff on corrective actions. Director will ensure that all facility staff receive training on the specific updates and changes to the home.</p>		

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	<p>operating direction over the facility to ensure a thorough investigation was conducted for clients #5, #6 and #8 in regard to abuse and injuries of unknown origin for clients #5, #6 and #8.</p> <p>3. Please see W331. The governing body failed to exercise general policy and operating direction over the facility to ensure nursing services developed and implemented a specific plan of care to indicate how the staff were to monitor client #1's diet, food intake, weight and blood pressure in regard to client #1's history of excess weight/obesity, hypertension, low potassium levels and refusals to comply with medical monitoring. The governing body failed to exercise general policy and operating direction over the facility to ensure the staff notified nursing services when not able to identify the dosage of a medication on the medication packet provided by the pharmacist and when medication labels were incorrectly labeled for clients #2, #4, #6 and #8 and to ensure the staff followed the facility's medication policy in giving the medications during the indicated windows of medication times for clients #3, #4, #5, #6 and #7.</p> <p>9-3-1(a)</p>		<p>Director has notified Pharmacy Manager to reduce the font size or abbreviate the name such that the dosage is not overlapped. This was completed on 1/8/14. How will other residents be identified as having the potential to be affected by the same deficient practice and what corrective action will be taken? All investigations will include interviews from all relevant parties. Director will initial all interviews within the investigation folder after reviewing, in addition to authorizing the overall investigation. Director will review all high risk plans, dining plans and weights for this facility. Director will receive a copy of weights from the nurse monthly. Director will receive a monthly list of appointments completed and refused/rescheduled from the nurse monthly. Any missed weights or appointments will be addressed with QIDP to develop any further disciplinary action or treatment plan as needed. Manager/QIDP and Nurse Consultant will review weekly cycle fill deliveries to ensure the font reduction occurred and allows readable dosages. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur? How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be</p>		

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W000149	<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. Based on record review and interview for 3 additional clients (#5, #6 and #8), the facility failed to implement its policy and procedures to ensure all client to client abuse and all injuries of unknown origin were thoroughly investigated.</p> <p>Findings include:</p> <p>The facility's reportable and investigative records were reviewed on 12/16/13 at 2:30 PM. ___7/19/13 BDDS (Bureau of Developmental Disabilities Services) report indicated on 7/19/13 at 1:30 PM while at Day Services (DS), client #6 was hit in the chest by a peer. The 7/19/13 Body Check Sheet (BCS) indicated client #6 complained of her</p>			W000149	<p>put into place?New Hope of Indiana Quality Assurance department will also continue to review all investigations and the presence of necessary interviews. Director and Quality Assurance Coordinator will also initial interviews within the investigation folder to ensure they are present. Director will continue to conduct random full nursing chart audits monthly. Director will spot check medication packaging monthly during routine site visits.</p> <p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. The governing body will review all investigations to note all required interviews are present. As noted in the survey interview, prior implementation of our procedure included gathering all relevant interviews as deemed appropriate by the person conducting the investigation, generally the QIDP. For incidents in which a client to client altercation was directly observed in its entirety (2 of the 3 incidents), it was not indicated as necessary to gather interviews from all parties, unless the investigation went in a direction that more information or perspective was needed. Going forward, all investigations will</p>		01/24/2014

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	<p>chest and neck hurting. The investigative summary of 7/19/13 indicated one interview was conducted with DS staff #5 on 7/19/13 at 1:30 PM. The investigative record indicated no notes of the interview. The investigative record indicated no further staff interviews and/or client interviews.</p> <p>__8/16/13 BDDS report indicated on 8/16/13 at 1:45 PM client #6 was sitting at a table at DS when a peer hit her on her right shoulder. The report indicated ice was applied to client #6's arm. The BCS dated 8/16/13 indicated client #6 had a reddened area of "5 inches" on her right shoulder. The investigative summary of 8/16/13 indicated one interview was conducted with DS staff #6 on 8/16/13 at 1:45 PM. The investigative record indicated no notes of the interview. The investigative record indicated no further staff interviews and/or client interviews.</p> <p>__11/24/13 Occurrence Outside Practice Standards (OOP's) report indicated client #8 was being assisted to the bathroom when she lost her balance and slid down to the floor to her bottom. The report indicated client #8 complained of pain in her left index finger then pointed to all of the fingers on her left hand and indicated she had no pain. The medical appointment form of 11/25/13 indicated client #8 was taken to see her doctor due</p>		<p>include interviews from all parties present, including the statement from the original staff observing the event and any other individuals or staff present/relevant to the investigation. In addition, all incidents that occur at Day Services will be directed by the residential home manager instead of the New Hope of Indiana Day Services. All injuries of unknown origin will include interviews with all staff. The investigation noted had those interviews, however, they were not maintained in the investigation folder at that time. They are now present in that investigation. Director will train all leadership on corrective actions. Director will ensure that all facility staff receive training on the specific updates and changes to the home. How will other residents be identified as having the potential to be affected by the same deficient practice and what corrective action will be taken. All investigations will include interviews from all relevant parties. Director will initial all interviews within the investigation folder after reviewing, in addition to authorizing the overall investigation. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur? How the corrective action will be monitored to ensure the deficient practice will not</p>		

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	<p>to swelling noted in her left hand and left foot pain. Client #8's x-ray reports of 11/26/13 indicated "minimally displaced fracture noted at the medial base of the proximal phalanx great toe (left)..." and "mildly displaced fracture noted at the base of the proximal phalanx of the index finger (left)..." The 11/29/13 investigative summary indicated "It is found likely and consistent that the fracture occurred during the fall in the restroom. The staff was providing appropriate care and supervision. There is no indication of purposeful or neglectful cause to this injury." The investigative summary of 11/29/13 indicated no staff or client interviews. __A Body Check Sheet (BCS) dated 11/24/13 found with the investigative records while reviewing the facility records, indicated the staff had found a 1 inch by 2 inch bruise on client #5's left elbow and a bruise under client #5's left little toenail. The facility's records indicated no investigation for client #5's injuries of unknown origin.</p> <p>Interview with the Group Home Director (GHD) on 12/19/13 at 2 PM indicated no further interviews for review in regard to the incidents of 7/19/13, 8/16/13 and 11/24/13. The GHD stated, "Since your last visit we have changed the way we are doing investigations to</p>		<p>recur; what quality assurance program will be put into place? New Hope of Indiana Quality Assurance department will also continue to review all investigations and the presence of necessary interviews. Quality Assurance Coordinator will also initial interviews to ensure they are present and the investigation is thorough.</p>				

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W000154	<p>make sure we include staff and client interviews for the client to client incidents that are observed." The GHD stated, "We have just always considered it to be enough if the incident was observed by staff." The GHD stated "only three" investigations were conducted within the past 12 months.</p> <p>Review of the revised 7/2012 facility policy of Suspected Abuse and Reporting policy on 12/16/13 at 2:30 PM indicated all reported allegations "will be investigated and documented." The policy indicated all reportable incidents were to be filed within 24 hours of incident or initial report with BDDS, BQIS (Bureau of Quality Improvement Services).</p> <p>9-3-2(a)</p> <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 record review and interview for 2 of 2 allegations of client to client abuse and for 2 of 2 injuries of unknown origin reviewed, the facility failed to ensure a thorough investigation was conducted for clients #5, #6 and #8.</p>	W000154	What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. The governing body will review all investigations to note all required interviews are present. As noted in the survey interview, prior implementation of our procedure	01/24/2014	

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	<p>Findings include:</p> <p>The facility's reportable and investigative records were reviewed on 12/16/13 at 2:30 PM.</p> <p>__7/19/13 BDDS (Bureau of Developmental Disabilities Services) report indicated on 7/19/13 at 1:30 PM while at Day Services (DS), client #6 was hit in the chest by a peer. The 7/19/13 Body Check Sheet (BCS) indicated client #6 complained of her chest and neck hurting. The investigative summary of 7/19/13 indicated one interview was conducted with DS staff #5 on 7/19/13 at 1:30 PM. The investigative record indicated no notes of the interview. The investigative record indicated no further staff interviews and/or client interviews.</p> <p>__8/16/13 BDDS report indicated on 8/16/13 at 1:45 PM client #6 was sitting at a table at DS when a peer hit her on her right shoulder. The report indicated ice was applied to client #6's arm. The BCS dated 8/16/13 indicated client #6 had a reddened area of "5 inches" on her right shoulder. The investigative summary of 8/16/13 indicated one interview was conducted with DS staff #6 on 8/16/13 at 1:45 PM. The investigative record indicated no notes of the interview. The investigative record indicated no further staff</p>		<p>included gathering all relevant interviews as deemed appropriate by the person conducting the investigation, generally the QIDP. For incidents in which a client to client altercation was directly observed in its entirety (2 of the 3 incidents), it was not indicated as necessary to gather interviews from all parties, unless the investigation went in a direction that more information or perspective was needed. Going forward, all investigations will include interviews from all parties present, including the statement from the original staff observing the event and any other individuals or staff present/relevant to the investigation. In addition, all incidents that occur at Day Services will be directed by the residential home manager instead of the New Hope of Indiana Day Services. All injuries of unknown origin will include interviews with all staff. The investigation noted had those interviews, however, they were not maintained in the investigation folder at that time. They are now present in that investigation. Director will train all leadership on corrective actions. Director will ensure that all facility staff receive training on the specific updates and changes to the home. How will other residents be identified as having the potential to be affected by the same deficient practice and what</p>				

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	<p>interviews and/or client interviews.</p> <p>__ 11/24/13 Occurrence Outside Practice Standards (OOP's) report indicated client #8 was being assisted to the bathroom when she lost her balance and slid down to the floor to her bottom. The report indicated client #8 complained of pain in her left index finger then pointed to all of the fingers on her left hand and indicated she had no pain. The medical appointment form of 11/25/13 indicated client #8 was taken to see her doctor due to swelling noted in her left hand and left foot pain. Client #8's x-ray reports of 11/26/13 indicated "minimally displaced fracture noted at the medial base of the proximal phalanx great toe (left)..." and "mildly displaced fracture noted at the base of the proximal phalanx of the index finger (left)..." The 11/29/13 investigative summary indicated "It is found likely and consistent that the fracture occurred during the fall in the restroom. The staff was providing appropriate care and supervision. There is no indication of purposeful or neglectful cause to this injury." The investigative summary of 11/29/13 indicated no staff or client interviews.</p> <p>__ A Body Check Sheet (BCS) dated 11/24/13 found with the investigative records while reviewing the facility records, indicated the staff had found a 1 inch by 2 inch bruise on client #5's left</p>		<p>corrective action will be taken. All investigations will include interviews from all relevant parties. Director will initial all interviews within the investigation folder after reviewing, in addition to authorizing the overall investigation. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur? How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place? New Hope of Indiana Quality Assurance department will also continue to review all investigations and the presence of necessary interviews. Quality Assurance Coordinator will also initial interviews to ensure they are present and the investigation is thorough.</p>				

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W000210	<p>elbow and a bruise under client #5's left little toenail. The facility's records indicated no investigation for client #5's injuries of unknown origin.</p> <p>Interview with the Group Home Director (GHD) on 12/19/13 at 2 PM indicated no further interviews for review in regard to the incidents of 7/19/13, 8/16/13 and 11/24/13. The GHD stated, "Since your last visit we have changed the way we are doing investigations to make sure we include staff and client interviews for the client to client incidents that are observed." The GHD stated, "We have just always considered it to be enough if the incident was observed by staff." The GHD stated "only three" investigations were conducted within the past 12 months.</p> <p>9-3-2(a)</p> <p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on observation, record review and interview for 2 of 4 sampled clients (#1 and #4), the facility failed to ensure the Interdisciplinary Team reassessed the clients' fine and gross motor skills,</p>	W000210	What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice?The facility has reviewed its procedure for reassessment of fine and gross motor skills, ambulation, therapy	01/26/2014

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	<p>mobility needs and level of assistance and supervision required while ambulating.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/16/13 between 4:30 PM and 6:30 PM and on 12/18/13 between 5:20 AM and 8:15 AM. Client #1 was an elderly woman who slumped forward and slightly to the right side while walking at a slow unsteady pace. Client #1 used a rolling walker during both observations and ambulated with and without staff assistance. Client #4 was an elderly woman who walked at a slow unsteady pace using a rolling walker. Client #4 wore a helmet and a gait belt while ambulating and the staff provided hands on assistance.</p> <p>Client #1's record was reviewed on 12/18/13 at 1 PM. Client #1's record indicated client #1 had a diagnosis of, but not limited to, Obesity. Client #1's record indicated client #1 had a history of falls, wore orthopedic shoes, AFO (Ankle-Foot Orthosis - an appliance or apparatus used to support/align the ankle) braces/splints and a gait belt while using a rolling walker whenever ambulating. Client #1's Physical Therapy (PT) evaluation of 1/4/12</p>		<p>needs. Annually, the QIDP is responsible to review with the team the needed assessment or reassessment for the individual. A specific IDT note has been developed to be used in conjunction with this IDT determination so proper documentation is maintained. All individuals with ambulation support needs, gait assistance or adaptive equipment such as walker, wheelchair will be reviewed by therapies annually or sooner if indicated. Client # 1 received order for reassessment, appointment scheduled for 1/29/14. Client #4 received order for reassessment, appointment completed 1/22/14. High Risk Plans and ISP to be updated and staff trained on current ambulation and support needs as recommended by therapy by 1/26/14. How will other residents be identified as having the potential to be affected by the same deficient practice and what corrective action will be taken. All other individuals were reviewed. 2 other individuals had therapy assessments that were due or coming due for reassessment. Both received orders and have been scheduled or completed. High Risk Plans and ISP to be updated and staff trained on current ambulation and support needs for these individuals as well by 1/26/14. What measure will be put into place or what systemic</p>		

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	<p>indicated a recommendation from PT for client #1 to "Keep walker close to body as walking to ensure safer movement/use of assistive device...."</p> <p>Client #1's Occupational Therapy (OT) evaluation indicated client #1 continued to need upper extremity range of motion. "Focus on shoulders/wrists. Practice grasp and release... Perform exercises 1 x daily." Client #1's record indicated no reassessment of client #1's fine and gross motor skills, mobility needs and/or level of assistance and supervision required while ambulating since the assessments by PT/OT dated 1/4/12.</p> <p>Client #4's record was reviewed on 12/18/13 at 4 PM. Client #4's record indicated client #4 had a diagnosis of, but not limited to, Osteoporosis (porous bones causing reduced bone strength and a higher risk of fractures) and she had a history of falls. Client #4's record indicated client #4 used a rolling walker and wore a helmet and gait belt while ambulating. Client #4's record indicated client #4 was last seen by OT on 3/10/11 and PT on 4/6/11 with recommendations from both for client #4 to continue with a home exercise program to include fine motor coordination tasks. Client #4's record indicated no reassessment of client #4's fine and gross motor skills, mobility needs and/or level of assistance</p>		<p>changes will be made to ensure that the deficient practices does not recur? How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place? IDT note specific for annual team review of therapies was developed. Nurse Consultant will add all relevant therapies to the routine appointment list. Director will receive a monthly list of appointments completed and refused/rescheduled from the nurse monthly. Any missed appointments will be addressed with QIDP to develop any further disciplinary action or treatment plan as needed. Director will continue to conduct random full nursing chart audits monthly.</p>	

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W000227	<p>and supervision required while ambulating since the assessments by PT/OT in March /April of 2011.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 12/19/13 at 3 PM indicated client #1's most current PT/OT assessment was conducted in January 2012. The QIDP indicated client #4's most current PT/OT assessment was conducted in March/April of 2011. The QIDP indicated no reassessment of client #1's and #4's fine and gross motor skills, mobility needs and/or level of assistance and supervision required while ambulating since the assessments conducted in 2011 and 2012.</p> <p>9-3-4(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review and interview for 3 of 4 sampled clients (#2, #3 and #4), the clients' Individual Support Plans (ISPs) failed to address the clients' identified training need in regards to leisure skills.</p>	W000227	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice? A specific leisure interest goal will be implemented for each individual. All staff were trained on active treatment expectations, meal engagement strategies and</p>	01/24/2014

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	<p>Findings include:</p> <p>Observations were conducted at the group home on 12/18/13 between 5:20 AM and 8:15 AM. There was one staff in the home for eight clients. From 5:20 AM until 6:10 AM, client #2 sat alone in the living room and clients #3 and #4, #6 sat in the dining room without activity. During this time staff #4 prepared the clients' meals and did not provide clients #2, #3 and #4 with training and/or choices of leisure activity.</p> <p>Client #2's record was reviewed on 12/18/13 at 2 PM. Client #2's ISP dated 7/1/13 indicated no objectives to assist the client with leisure skills.</p> <p>Client #3's record was reviewed on 12/18/13 at 3 PM. Client #3's ISP dated 8/14/13 indicated indicated no objectives to assist the client with leisure skills.</p> <p>Client #4's record was reviewed on 12/18/13 at 4 PM. Client #4's ISP dated 8/16/13 indicated no objectives to assist the client with leisure skills.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 12/19/13 at 3 PM indicated the staff</p>		<p>leisure interest ideas. How will other residents be identified as having the potential to be affected by the same deficient practice and what corrective action will be taken?A leisure interest goal was implemented for all individuals in the home. All goals will be indicated on ISP.What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur? How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place?Manager and Team Leader will make daily observations that active treatment opportunities are being offered for 2 weeks of correction period. Weekly home observations will resume at that point given satisfactory staff progress toward expectations. Monthly case management and goal review will give indication of progress toward goals of gaining independence in leisure interest areas.</p>				

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W000240	<p>were to provide the clients with choices of leisure activity when not involved in training. The QIDP indicated no objectives to assist clients #2, #3 and #4 with leisure skills. The QIDP stated, "They (clients #2, #3 and #4) should have been involved with the meal prep."</p> <p>9-3-4(a)</p> <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on record review and interview for 3 of 4 sampled clients (#1, #3 and #4), the clients' ISPs (Individualized Support Plans) failed to address how the staff were to supervise, monitor and assist clients #1 and #4 while ambulating, what the staff were to monitor/document in regards to client #1's and #3's memory loss and how the staff were to assist clients #1 and #3 throughout the day in regard to memory loss.</p> <p>Findings include:</p> <p>1. Observations were conducted at the group home on 12/16/13 between 4:30 PM and 6:30 PM and on 12/18/13</p>	W000240	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice? Client # 1 received order for PT reassessment, appointment scheduled for 1/29/14. Client #4 received order for PT reassessment, appointment completed 1/22/14. High Risk Plans and ISP to be updated and staff trained on current ambulation and support needs as recommended by therapy by 1/26/14. Client #1, #3 and #4 to be assessed and evaluated by Behavior Consultant and psychiatry to determine diagnostic and treatment goals for their conditions. Nurse Consultant to confer with neurology to determine specific symptoms for</p>	01/24/2014

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	<p>between 5:20 AM and 8:15 AM.</p> <p>__ Client #1 was an elderly woman who slumped forward and leaned slightly to the right side while walking at a slow unsteady pace. Client #1 used a rolling walker during both observations and was observed ambulating with and without staff assistance.</p> <p>__ Client #4 was an elderly woman who walked at a slow unsteady pace using a rolling walker. Client #4 wore a helmet and a gait belt while ambulating and the staff provided hands on assistance during ambulation.</p> <p>Client #1's record was reviewed on 12/18/13 at 1 PM. Client #1's record indicated client #1 had a diagnosis of, but not limited to, Obesity. Client #1's record indicated client #1 had a history of falls, wore orthopedic shoes, AFO (Ankle-Foot Orthosis - an appliance or apparatus used to support/align the ankle) braces/splints and a gait belt while using a rolling walker whenever ambulating. Client #1's Physical Therapy (PT) evaluation of 1/4/12 indicated a recommendation from PT for client #1 to "Keep walker close to body as walking to ensure safer movement/use of assistive device...."</p> <p>Client #1's Occupational Therapy (OT) evaluation indicated client #1 continued to need upper extremity range of motion.</p>		<p>tracking memory loss. Tracking will be developed to capture indicators in conjunction with Behavior Consultant and BSP. How will other residents be identified as having the potential to be affected by the same deficient practice and what corrective action will be taken? All other individuals were reviewed to have appropriate interventions toward independence. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur? How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place? Manager will give a competency quiz to staff on or before 2/14 after training on ambulation supports and assistance. Manager and Team Leader will make daily observations that ambulation assistance is appropriately offered for the first 2 weeks of correction period. Weekly home observations will resume at that point given satisfactory staff progress toward expectations. Manager/QIDP will review data and tracking weekly to ensure consistency in documentation on memory symptoms. Behavior Consultant will update Behavior Support Plan and indicate what symptoms staff are to track as indicated by psychiatry. Behavior will review progress monthly in</p>		

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	<p>"Focus on shoulders/wrists. Practice grasp and release... Perform exercises 1 x daily." Client #1's ISP dated 7/30/13 and client #1's Falls Risk Plan of 9/16/13 did not indicate how the staff were to supervise, monitor and assist client #1 while ambulating.</p> <p>Client #4's record was reviewed on 12/18/13 at 4 PM. Client #4's record indicated client #4 had a diagnosis of, but not limited to, Osteoporosis (porous bones causing reduced bone strength and a higher risk of fractures) and she had a history of falls. Client #4's record indicated client #4 used a rolling walker and wore a helmet and gait belt while ambulating. Client #4's record indicated client #4 was last seen by OT on 3/10/11 and PT on 4/6/11 with recommendations from both for client #4 to continue with a home exercise program to include fine motor coordination tasks. Client #4's ISP dated 8/16/13 and client #4's Falls Risk Plan of 9/16/13 did not indicate how the staff were to supervise, monitor and assist client #4 while ambulating.</p> <p>Telephone interview with the Licensed Practical Nurse (LPN) on 12/19/13 at 1 PM indicated client #1's and #4's Falls Risk Plans did not include how the staff were to supervise, monitor and assist clients #1 and #4 while ambulating.</p>		<p>progress note and continue quarterly psychiatry consultations. Director will continue random monthly behavior audits. Director will continue monthly site visits as well.</p>				

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	<p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 12/19/13 at 3 PM indicated client #1's and #4's ISPs did not include how the staff were to supervise, monitor and assist clients #1 and #4 while ambulating.</p> <p>2. Client #1's record was reviewed on 12/18/13 at 1 PM. Client #1's 12/2013 quarterly physician's orders indicated client #1 was taking Aricept 10 mg (milligrams) at bedtime for memory loss. Client #1's record failed to include a plan to include what the staff were to monitor in regard to client #1's memory loss and how the staff were to assist the client in regard to her memory loss.</p> <p>Client #3's record was reviewed on 12/18/13 at 3 PM. Client #3's 12/2013 quarterly physician's orders indicated client #3 used Exelon patches daily for memory loss. Client #3's record failed to include a plan to include what the staff were to monitor in regard to client #3's memory loss and how the staff were to assist the client in regard to his memory loss.</p> <p>Telephone interview with the LPN on 12/19/13 at 1 PM indicated client #1's and #3's plans of care did not include</p>			
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W000249	<p>how the staff were to supervise and monitor clients #1 and #3 in regard to memory loss and/or include how the staff were to assist the clients throughout the day.</p> <p>Interview with the QIDP on 12/19/13 at 3 PM indicated client #1's and #3's plans of care did not include how the staff were to supervise and monitor clients #1 and #3 in regard to memory loss and/or include how the staff were to assist the clients throughout the day.</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, 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. Based on observation, interview and record review for 3 of 4 sampled clients (#2, #3 and #4) and 3 additional clients (#6, #7 and #8), the facility failed to ensure the clients were offered formal and informal training opportunities and/or choices of leisure activities when time permitted.</p> <p>Findings include:</p>	W000249	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice? How will other residents be identified as having the potential to be affected by the same deficient practice and what corrective action will be taken? All staff were retrained on the objectives and training opportunities for all individuals. Meal planning and preparation</p>	01/24/2014	

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	<p>Observations were conducted at the group home on 12/18/13 between 5:20 AM and 8:15 AM. There was one staff in the home for eight clients. From 5:20 AM until 6:10 AM, client #2 sat alone in the living room and clients #3, #4, #6, #7 and #8 sat in the dining room without activity. During this time staff #4 prepared the clients' meals and did not provide clients #2, #3, #4, #6, #7 and #8 with training and/or choices of leisure activity.</p> <p>Client #2's record was reviewed on 12/18/13 at 2 PM. Client #2's ISP (Individualized Support Plan) dated 7/1/13 indicated objectives to wash her legs, to brush the right side of her hair, to brush her teeth, to put a napkin in her lunch box, to put the receipt from a purchase in a safe place and to take small bites of food when eating.</p> <p>Client #3's record was reviewed on 12/18/13 at 3 PM. Client #3's ISP dated 8/14/13 indicated objectives to shower, to point to the correct signature line on a check, to brush his teeth, to put on his belt independently and to put one item in his lunchbox.</p> <p>Client #4's record was reviewed on 12/18/13 at 4 PM. Client #4's ISP of</p>		<p>was reviewed with strategies to engage and direct active treatment ideas. All Dining plans were reviewed as well. In addition, the specific dysphagia recommendations in regard to safe eating (setting down utensil, alternating sip and bite) were reviewed. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur? How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place? Manager and Team Leader will make daily observations that active treatment opportunities are being offered for the first 2 weeks of correction period. These observations will include leisure skills opportunities as well as those skills relevant to meal preparation and safe eating. Weekly home observations will resume at that point given satisfactory staff progress toward expectations. Monthly case management and goal review will give indication of progress toward goals of gaining independence in leisure interest areas. Dietician will continue to monitor appropriate implementation of menu and dining plans at quarterly observations.</p>	

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	<p>8/16/13 indicated objectives to put her dirty clothes in the hamper, to wash her hands, to brush her teeth, to count dollar bills up to five dollars, to name five items in a magazine, to prepare a side dish and to put her silverware at her place setting.</p> <p>Client #6's record was reviewed on 12/18/13 at 4 PM. Client #4's ISP of 7/23/13 indicated client #6 "Needs ongoing assistance with completing proper healthy hygiene tasks, money skills, medications and household skills."</p> <p>Client #7's record was reviewed on 12/18/13 at 4 PM. Client #4's ISP of 8/1/13 indicated client #7 "Needs ongoing assistance with completing proper healthy hygiene tasks, money skills, medications and household skills."</p> <p>Client #8's record was reviewed on 12/18/13 at 4 PM. Client #4's ISP of 8/1/13 indicated client #8 "Needs ongoing assistance with completing proper healthy hygiene tasks, money skills, medications and household skills."</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) on</p>				

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W000312	<p>12/19/13 at 3 PM indicated the staff were to prompt/provide the clients with informal and formal training at every opportunity. The QIDP stated the clients "should not" be sitting for long periods of time without being prompted to an activity or training. The QIDP stated, "They (clients #2, #3, #4, #6, #7 and #8) should have been involved with the meal prep."</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 record review and interview for 4 of 4 sampled clients receiving medications to control behaviors (clients #1, #2, #3 and #4), the facility failed to ensure a plan of reduction for each psychoactive medication taken by the clients that was attainable for the clients and to ensure client #1's use of Cogentin was included in the client's Behavior Support Plan (BSP).</p> <p>Findings include: Client #1's record was reviewed on</p>	W000312	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice? How will other residents be identified as having the potential to be affected by the same deficient practice and what corrective action will be taken? Behavior Plans for all individuals were reviewed. For those clients identified, the psychiatrist adjusted the reduction criteria appropriately. Client #2 had recently been moved from another home due to extensive physical altercations with a housemate. The team feels she remains on an</p>	01/24/2014			

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	<p>12/18/13 at 1 PM. Client #1's 12/2013 quarterly physician's orders indicated client #1 took Sertraline (Zoloft) 150 mg (milligrams) a day for mood disorder, Abilify 7.5 mg (milligrams) a day for Schizophrenia and Benztropine .5 mg every 12 hours as needed for EPS (extrapyramidal symptoms from the use of psychotropic medications). Client #1's Behavior Support Plan (BSP) dated 10/1/13 indicated client #1 had targeted behaviors of refusals to get up, verbal/physical aggression, noncompliance and refusal to attend the day program. The BSP indicated Abilify would be considered for reduction by 2.5 mg once client #1 demonstrated zero incidents verbal and physical aggression for 6 consecutive months. The plan indicated the Zoloft would be considered for reduction next. The BSP failed to include the use of Cogentin.</p> <p>Client #2's record was reviewed on 12/18/13 at 2 PM. Client #2's 12/2013 quarterly physician's orders indicated client #2 took Abilify 5 mg a day for Bi Polar Disorder and Risperdal 1 mg a day for aggression. Client #2's BSP indicated client #2 had targeted behaviors of verbal/physical aggression, crying and noncompliance. Client #2's BSP indicated Risperdal would be considered for reduction following zero incidents of</p>		<p>appropriate dose of medication. Given her recent move and the severity and frequency of the altercations, it was felt that zero incidences for a chronic mental condition at this time was appropriate. Her plan will be reviewed to consider change to her reduction plan. At this time she is doing fairly well and its possible that psychiatry may consider a med reduction based on verbal aggression progress. Team would not find a reduction of medications appropriate if anything less than zero physical aggressions occurred, again based on recent concerns. Client #3 experiences symptoms of schizophrenia to the extent that his day is significantly interrupted. The IDT supports the least amount of pharmacology necessary, but understands that long term medication treatment is most likely part of the successful treatment plan for his condition. In addition, client #3 appears to be managing successfully at a therapeutic dosage of medications. The functional behavioral assessment will further outline the needed maintenance of a long term medication plan for him. In addition, the plan of reduction was adjusted to allow reductions to occur with incidences greater than zero times. Client #4 reduction plan was adjusted to above zero incidences for target behaviors. Cogentin was</p>	

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	<p>verbal and physical aggression for six consecutive months.</p> <p>Client #3's record was reviewed on 12/18/13 at 3 PM. Client #3's 12/2013 quarterly physician's orders indicated client #3 took Clozapine 375 mg a day for Schizophrenia and Melatonin 3 mg a night for a sleep aide. Client #3's BSP indicated client #3 had targeted behaviors of refusals, isolation, wandering off and high levels of anxiety. Client #3's BSP indicated the Clozapine would be considered for reduction by 25 mg once client #3 demonstrated zero frequency of the target behavior of "high levels of anxiety" for 6 consecutive months. The plan indicated the Melatonin would be considered for reduction next.</p> <p>Client #4's record was reviewed on 12/18/13 at 4 PM. Client #4's 12/2013 quarterly physician's orders indicated client #4 took Zyprexa 17.5 mg and Lexapro 20 mg a day for anxiety. Client #4's BSP indicated client #4 had targeted behaviors of high levels of repetitive speech, behavioral outbursts, physical aggression and walking without staff assistance. The BSP indicated "When [client #4] displays zero incidents of physical aggression and behavioral outbursts for one year she will be</p>		<p>discontinued per psychiatry for Client #1 and one additional Client #6. All Behavior Plans were reviewed and no other plans had target behavior as zero. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur? How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place? Manager/QIDP and Director will continue to review all Behavior Plans. Director will continue to do random behavior chart audits monthly.</p>		

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W000323	<p>eligible for reduction. Zyprexa will be considered for reduction by 2.5 mg and once it is discontinued Lexapro will be considered for reduction."</p> <p>During interview with the QIDP (Qualified Intellectual Disabilities Professional) and the BS (Behavior Specialist) on 12/19/13 at 2 PM, when asked if clients #1, #2, #3 and #4 could attain their goals of zero incidents/behaviors in 6 or 12 months and were these realistic goals/plans for each of the clients, the BS stated, "I guess we will need to look at them." The QIDP stated, "I see what you're saying and the team will have to look at each client and their behavior data to come up with more attainable goals for reduction."</p> <p>Telephone interview with the QIDP on 12/27/13 indicated client #1's PRN use of Cogentin was not included in the client's BSP.</p> <p>9-3-5(a)</p> <p>483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p>			
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	<p>Based on record review and interview for 3 of 4 sampled clients (#1, #3 and #4), the facility failed to ensure the clients' vision and hearing were evaluated annually.</p> <p>Findings Include:</p> <p>Client #1's record was reviewed on 12/18/13 at 1 PM. Client #1's annual physical examination of 9/26/13 indicated "Needs annual eye exam" and "Needs annual hearing assessment." Client #1's record indicated client #1's most current vision evaluation was conducted on 10/22/12. Client #1's record indicated client #1's most current hearing evaluation was conducted on 10/9/12.</p> <p>Client #3's record was reviewed on 12/18/13 at 3 PM. Client #3's annual physical examination of 2/14/13 indicated no evidence of a vision evaluation. Client #3's record indicated client #3's most current vision evaluation was conducted on 11/5/12.</p> <p>Client #4's record was reviewed on 12/18/13 at 4 PM. Client #4's annual physical examination of 11/22/13 indicated no evidence of a vision evaluation. Client #4's record indicated client #4's most current vision</p>	W000323	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice? Eye and hearing evaluations for identified clients were scheduled and will be completed as scheduled. How will other residents be identified as having the potential to be affected by the same deficient practice and what corrective action will be taken. All other appointments for this facility were audited. Those due were scheduled as indicated in addition to PT evaluations. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur? How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place. Nurse Consultant will continue to give monthly appointment sheet (listing appointments to be made) to Team Leader. Site will make appointments and return appointment schedule information to nurse consultant. Nurse Consultant will continue to maintain her system to monitor appointments and follow up. Nurse Consultant will submit a copy of all appointments scheduled and completed as well as refusals or rescheduled appointments to Director monthly. Any missed appointments will be addressed</p>	01/24/2014			

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W000331	<p>evaluation was conducted on 11/1/12.</p> <p>Interview with the Licensed Practical Nurse (LPN) on 12/19/13 at 1 PM indicated the most current vision and hearing evaluations were in the clients' records for review. The LPN stated clients #3 and #4 were scheduled for vision evaluations "next month."</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 12/19/13 at 3 PM indicated the recommendations made by the physician for client #1 to have an annual vision and hearing evaluation had been overlooked and would be addressed.</p> <p>9-3-6(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) and 4 additional clients (#5, #6, #7 and #8), the facility nursing services failed: __To develop and implement a specific plan of care to indicate how the staff were to monitor client #1's diet, food intake, weights and blood pressure in regard to client #1's history of excess weight/obesity, hypertension,</p>	W000331	<p>with QIDP to develop any further disciplinary action or treatment plan as needed.</p> <p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice? Nursing services has reviewed HRP's for Client #1. All plans were updated to have specific parameter for notification of the nurse. Diet and food intake is monitored by providing ordered diet plan. Vital signs have been identified specific for her. Blood pressure to be taken weekly. Weights are</p>	01/24/2014			

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	<p>low potassium levels and refusals to comply with medical monitoring.</p> <p>__To ensure the staff notified the nurse when not able to identify the dosage of the medication on the medication packets provided by the pharmacist and when medication labels were incorrectly labeled for clients #2, #4, #6 and #8.</p> <p>__To ensure the staff followed the facility medication policy in giving the medication during the indicated windows of medication times for clients #3, #4, #5, #6 and #7.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 12/18/13 at 1 PM. Client #1's record indicated diagnoses of, but not limited to, Obesity, Hypertension and Hypokalemia (low potassium).</p> <p>__Client #1's 12/2013 quarterly physician's orders indicated client #1 was taking Lisinopril 40 mg (milligrams), Losartan Potassium 50 mg, Maxzide 75/50 mg and Verapamil 240 mg a day for hypertension (high blood pressure) and Potassium Chloride 20 ml (milliliters) a day for Hypokalemia (low potassium levels). The orders indicated the client was to be weighed monthly and blood pressure was to be taken weekly.</p> <p>__Client #1's Nutritional Assessment</p>		<p>to be obtained monthly and will begin the first week of the month for client #1 to offer several opportunities.High Risk Plan for hypokalemia has been developed and staff were trained. GTube liquid medication was removed 12/27/13 and replaced with correctly labeled liquid stating "taken orally".All individuals in home were reviewed to note appropriate method for administration of medications was indicated and noted on medication administration sheet if taken with a medium or in an altered format (crushed). In addition, all treatments were moved from overnight shift responsibility and changed timing to better facilitate accurate usage.Overnight staff, in addition to all other staff, was retrained on the appropriate timing of medication administration. Medication administration times were also posted on the medication cabinet. At times, many of our staff work at other providers and the administration policies may be different. And each home/facility may have varying times which can be better communicated with this posting. How will other residents be identified as having the potential to be affected by the same deficient practice and what corrective action will be taken.Director has reviewed all orders, high risk plans, dining plans and weights for this facility</p>		

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	<p>from the dietician dated 9/29/13 indicated the dietician was "unable to assess weight trends, only one weight available this past year of 149# (pounds) - client has hx (history) of refusals for weight. AWR (Average weight range) 99 - 121#. Need to have consistent monthly weights or offer at different times during the month to get weight. Client would benefit from weight loss due to HTN (hypertension)." Review of a 12/20/13 email from the Qualified Intellectual Disabilities Professional (QIDP) on 12/20/13 at 10:30 AM indicated a list of client #1's weights for 2013. The email indicated client #1 had refused to be weighed in January, February, April, June, July and August of 2013. The email indicated client #1's last recorded weight in December 2013 of 178.6 pounds, a weight gain of 29.6 pounds since the dietician's assessment in September.</p> <p>__Client #1's 2013 Cardiovascular Plan indicated to call the nurse if client #1's blood pressure was "higher than normal for person." The plan did not define what "normal for person" meant. The plan indicated "routine vitals." The plan was not specific to client #1 and did not include parameters of high and low blood pressure for client #1. Client #1's record indicated client #1 consistently refused having her blood pressure taken.</p>		<p>with nurse consultant and QIDP. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur? How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place. Director will receive copy of monthly appointments, weekly blood pressures as well as weights to ensure Client #1 complies with medical monitoring. In the event her noncompliance puts her at risk, the IDT will meet to determine what necessary interventions need to be implemented. Director has notified Pharmacy Manager to reduce the font size or abbreviate the name such that the dosage is not overlapped. This was completed on 1/8/14. Nurse consultant and QIDP will ensure daily medication and meal observations are conducted for 2 weeks after 1/21/14 training to ensure consistency in implementing treatment plans and medication administration. Assuming competency, the observations will resume to monthly by nurse consultant. Those observations will allow monitoring of medication administration competence as well as medication labeling.</p>		

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	<p>__ Client #1's record failed to include a specific plan of care to indicate how the staff were to monitor client #1's diet, food intake, weight and blood pressure in regard to client #1's history of excess weight/obesity, hypertension, low potassium levels and refusals to comply with medical monitoring.</p> <p>During a telephone interview with the Licensed Practical Nurse (LPN) on 12/19/13 at 1 PM, the LPN stated, "I'm in the process of updating all of the risk plans." The LPN indicated client #1 did not have a plan in place to address what the staff were to do when client #1 refused medical monitoring. The LPN indicated client #1's record did not have a health care plan in place in regard to obesity or Hypokalemia. The LPN indicated client #1's health plan for hypertension did not define "normal" for client #1 and/or provide the parameters of when to call the nurse.</p> <p>2. Observations were conducted at the group home on 12/18/13 between 5:20 AM and 8:15 AM. The facility used an individualized packaging system with each client's medications packaged per dosing time. During this observation the following was observed:</p> <p>At 7 AM staff #1 opened client #4's medication packets. One package was</p>						

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	<p>labeled one Metoprolol Tartrate (for high blood pressure), one Loratadine (for allergies) 10 mg (milligrams), one Escitalopram (for depression) 20 mg. and the other package was labeled one Metoprolol Tartrate. The dosage of the Metoprolol Tartrate on both packets was hidden behind the name of the medication and was unable to be read. Staff #1 emptied both packets into a medication cup and gave the medications to client #4. Client #4 did not receive Thera Tab (a vitamin supplement) during this observation period.</p> <p>At 7:15 AM staff #1 opened a medication packet for client #8 labeled with one Doxycycline (for infections) 50 mg and three Divalproex Sprinkles (for seizures). The dosage of the Divalproex Sprinkles was hidden behind the name of the medication on the packet and was unable to be read. Staff #1 then got a bottle from the medication cabinet labeled with client #8's name and Calcium Carb 6 ml (milliliters) per Gastrostomy Tube (G-Tube) twice daily. Staff #1 crushed client #8's medications and mixed the Calcium Carb along with the crushed medications into yogurt and fed it to client #8. Staff #1 stated, "She doesn't have a G-tube any more so I just put it in her yogurt and give it to her."</p> <p>At 7:30 AM staff #1 opened a</p>						

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	<p>medication packet for client #2 labeled with one Vita (vitamin) E 100 IU (international units), three Phenytoin Chewable (for seizures) and one Docusate Sodium (a stool softener) 100 mg. The dosage of the Phenytoin Chewable was hidden behind the name of the medication on the packet and was unable to be read. Staff #1 emptied the packet into a medication cup and gave the medications to client #2.</p> <p>At 7:45 AM staff #1 opened a medication packet for client #6 labeled with one Hydroxychloroquine (for Lupus) and three Fluvoxamine Maleate (for depression) 25 mg and one Carbamazepine (for seizures) 100 mg. The dosage of the Hydroxychloroquine was hidden behind the name of the medication on the packet and was unable to be read. Staff #1 emptied the packet into a medication cup and gave the medications to client #6. Client #6 did not receive Cogentin (for extrapyramidal symptoms) 0.5 mg during this observation period.</p> <p>Client #3 did not receive Loratadine (for sinus congestion) 10 mg (milligrams) or Clozapine (for Schizophrenia) 25 mg, client #5 did not receive Omeprazole (an antacid) 20 mg and client #7 did not receive Certavite Liquid (a vitamin supplement) 15 ml during this observation period.</p>			

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	<p>Review of the facility MAR (Medication Administration Record) on 12/18/13 at 1 PM indicated:</p> <p>Client #2 was to have Phenytoin Chewable 50 mg three tablets every AM.</p> <p>Client #3 was to have Loratadine 10 mg and Clozapine 25 mg at 6 AM.</p> <p>Client #4 was to have Metoprolol Tartrate 50 mg two tablets every AM and Thera Tab at 6:30 AM.</p> <p>Client #5 was to have Omeprazole 20 mg. at 6 AM.</p> <p>Client #6 was to have Hydroxychloroquine 200 mg one tablet every AM and Cogentin 0.5 mg. at 6 AM.</p> <p>Client #7 was to have Certavite Liquid 15 ml at 6 AM.</p> <p>Client #8 was to have Divalproex Sprinkles 125 mg 3 capsules every AM.</p> <p>Review of client #8's record on 12/19/13 at 3 PM indicated a note from the facility nurse on 8/2/13 "[Client #8] is doing very well with her oral feedings. Can you please write an order to D/C (discontinue) meds through G-tube and start on meds orally. The physician responded on 8/6/13 with an order to D/C medications through the G-tube and to give all medications orally. The physician indicated the medications</p>				

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	<p>could be crushed and put in pudding or yogurt.</p> <p>Review of the revised 6/2013 facility Medication Administration policy on 12/19/13 at 1 PM indicated "When passing prescribed medications, all such associates will follow the specific steps outlined in the Medication Administration Core A and B training course."</p> <p>Review of the 2004 Medication Administration Core A and B manual on 12/19/13 at 4 PM indicated "If medications were not administered within 30 minutes prior to or after the prescribed time, you must chart the exact time you administer it."</p> <p>Interview with staff #4 on 12/18/13 at 5:20 AM indicated the staff had given clients #3, #4, #6, #7 and #8 their early AM medications. When asked what was the facility time frame/window of medications administration, staff #4 stated, "I think it's an hour before and an hour after."</p> <p>Interview with staff #1 on 12/18/13 at 8 AM indicated the staff was not able to read the dosage on all of the medication packets for the clients. When staff #1 was asked how she knew what dosage</p>				

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	<p>she was giving the clients if she was not able to read the pharmacy packaging, staff #1 stated, "I just go by what's on the medication record."</p> <p>During a telephone interview with the Licensed Practical Nurse (LPN) on 12/19/13 at 1 PM, the LPN stated, "The staff should have notified me if they couldn't read the dosage on the medication packet." The LPN indicated checking the dosage of the medication to the medication administration record was part of the triple check that was to be conducted every time a medication was given and if the staff was unable to read the dosage on the prepackaged medication then the staff was to notify nursing services. The LPN indicated she was not made aware of a problem with the pharmacy labeling. The LPN indicated client #8 "Used to have a G-tube but it has been removed." The LPN stated the label on the bottle of Calcium for client #8 "should have" been changed after the client's G-tube was removed. The LPN indicated the facility practice was for medications to be given within 1/2 hour before or 1/2 hour after the prescribed time on the MAR. The LPN indicated if the staff were not able to give the medications within that time frame, the staff were to notify the nurse. The LPN indicated she</p>			

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W000369	<p>had not been notified of any discrepancies or medication errors for the morning of 12/18/13.</p> <p>9-3-6(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 52 medications observed being administered, the facility failed to ensure all medications were administered without error to client #8.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/18/13 between 5:20 AM and 8:15 AM. During this observation client #8 did not receive Chlorhexidine Gluconate Solution to her teeth.</p> <p>Review of the facility MAR (Medication Administration Record) on 12/18/13 at 1 PM indicated client #8 was to have Chlorhexidine Gluconate Solution 15 ml (milliliters) brushed on her teeth at 7 AM. The MAR indicated no staff initials for 7 AM on 12/18/13 indicating the</p>	W000369	All individuals in home were reviewed to note appropriate method for administration of medications was indicated and noted on medication administration sheet if taken with a medium or in an altered format (crushed). In addition, all treatments were moved to different time periods to better facilitate accuracy in administration times. Nurse consultant and QIDP will ensure daily medication and meal observations are conducted for 2 weeks after 1/21/14 training to ensure consistency in implementing treatment plans and medication administration. Assuming competency, the observations will resume to monthly by nurse consultant. Those observations will allow monitoring of medication administration competence as well as medication labeling.	01/24/2014

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W000436	<p>Chlorhexidine Gluconate Solution was not provided to client #8.</p> <p>During a telephone interview with the Licensed Practical Nurse (LPN) on 12/19/13 at 1 PM, the LPN indicated all medications were to be given as prescribed by the physician and administered without error.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview for 2 of 4 clients (#2 and #7) using adaptive dining equipment, the facility failed to provide the clients training in the use of a rocker knife.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/16/13 between 4:30 PM and 6:30 PM. During this observation clients #2 and #7 were observed eating their evening meal of meatloaf, mashed potatoes, a broccoli and cauliflower mix, a slice of bread and</p>	W000436	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice? How will other residents be identified as having the potential to be affected by the same deficient practice and what corrective action will be taken? All staff were trained on the proper use of adaptive equipment, including rocker knives for meal involvement. Staff were guided on how this tool is a resource for the individuals' independence. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices</p>	01/24/2014

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	<p>mandarin oranges. A rocker knife sat on the table between clients #3 and #7 and another one nearby client #2. The clients did not use the rocker knife to cut their food. The staff cut client #2's and #7's food for them. Clients #2 and #7 were not prompted to use the rocker knife themselves and/or provided training on how to use the knife.</p> <p>Observations were conducted at the group home on 12/18/13 between 5:20 AM and 8:15 AM. During this observation clients #2 and #7 were observed eating their morning meal of cold cereal/oatmeal and waffles/pancakes. Staff #4 used the rocker knife to cut up client #2's and #7's waffles/pancakes. Clients #2 and #7 were not prompted to use the rocker knife themselves and/or provided training on how to use the knife.</p> <p>Client #2's record was reviewed on 12/18/13 at 2 PM. Client #2's dining plan of 7/8/13 indicated client #2's adaptive dining equipment included a rocker knife. Client #2's ISP (Individualized Support Plan) dated 7/1/13 indicated no objectives to teach client #2 to learn to use the rocker knife.</p> <p>Client #7's record was reviewed on 12/18/13 at 4 PM. Client #7's dining</p>		<p>does not recur? How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place? Nurse consultant and QIDP will ensure daily meal observations are conducted for 2 weeks after 1/21/14 training to ensure consistency in implementing treatment and dining plans.. Assuming competency, the observations will resume to monthly by QIDP or Team Leader.</p>		

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W000455	<p>plan of 8/1/13 indicated client #7's adaptive dining equipment included a rocker knife. Client #7's ISP dated 7/1/13 indicated no objectives to teach client #7 to learn to use the rocker knife.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 12/19/13 at 3 PM indicated the staff were to prompt clients #2 and #7 to use the rocker knife with hand over hand assistance and to provide training to use the knife at every meal when appropriate. The QIDP indicated client #2's and #7's ISPs did not include any objectives to teach clients #2 and #7 to use a rocker knife.</p> <p>9-3-7(a)</p> <p>483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation and interview for 8 of 8 clients living in the group home (clients #1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to maintain proper hygiene practices to prevent cross contamination of germs due to clients sneezing and coughing.</p> <p>Findings include:</p>	W000455	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice? How will other residents be identified as having the potential to be affected by the same deficient practice and what corrective action will be taken. All staff have been trained on infection control issues related to sneezing, coughing and what to do if this occurs during a meal.</p>	01/24/2014

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	<p>Observations were conducted at the group home on 12/16/13 between 4:30 PM and 6:30 PM. While the evening meal was being prepared client #6 walked in and out of the kitchen and sneezed/coughed while standing close by the food. Client #6 did not cover her mouth. Staff #1 stated, "Bless you" to client #6. At 5:40 PM clients #1, #2, #3, #4, #5, #6, #7 and #8 were all sitting at the dining room table. Staff #1 and #3 were in the kitchen preparing mashed potatoes and staff #3 was placing bread on the table. Client #6 sneezed two more times, not covering her mouth and droplets of airborne fluid sprayed from her mouth over the table/food. Client #8 stated, "Bless you" at the same time staff #1 stated, "Bless you." During the meal clients #3, #6 and #8 coughed and/or sneezed. During this observation the staff did prompt the clients to cover their mouth when sneezing and/or coughing.</p> <p>Observations were conducted at the group home on 12/18/13 between 5:20 AM and 8:15 AM. At 5:30 AM clients #3, #4, #6, #7 and #8 were in the dining room waiting for their breakfast. During this time clients #6 and #8 coughed while sitting in the dining room. Staff #4 was preparing the morning breakfast and did not prompt the clients to cover their mouth when coughing. Staff #4 stated</p>		<p>Director sent CDC "Cover Your Cough" signage to all facilities to post as visual reminders for residents and staff. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur? How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place? Nurse consultant and QIDP will ensure daily meal observations are conducted for 2 weeks after 1/21/14 training to ensure consistency in implementing treatment and dining plans.. Assuming competency, the observations will resume to monthly by QIDP or Team Leader. During these observations as well as med administration observations, the supervisory staff can ensure staff follow proper infection control technique. Annual flu vaccination occurs for all associates in Oct. In addition, an educational component is presented in all staff training. The curriculum for this will be revised to include meal time situations.</p>				

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W000460	<p>when client #8 coughed, "Are you ok?" Client #8 stated, "Yes, I'm hungry."</p> <p>Interview with staff #4 on 12/18/13 at 7 AM indicated when the clients sneezed and/or coughed, the staff were to prompt the clients to cover their mouth and wash their hands.</p> <p>Interview with the Licensed Practical Nurse (LPN) on 12/19/13 at 1 PM stated the staff "should have" prompted the clients to cover their mouths when coughing and or sneezing and to wash their hands afterwards.</p> <p>9-3-7(a)</p> <p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>Based on observation, record review and interview for 8 of 8 clients living in the group home (clients #1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to ensure the staff followed the facility menu and substitution list to prepare the clients' meal.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/18/13 between 5:20</p>	W000460	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice? New Hope of Indiana reviewed procedures for substitution process. Our procedure is still current best practice and remains appropriate. Staff had previously been trained on the use of the substitution document but had gradually stopped using the tool appropriately. The document was hanging on the refrigerator at time of survey behind the</p>	01/24/2014

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	<p>AM and 8:15 AM. At 5:30 AM clients #1 and #5 were still in bed. Client #2 was in the living room and clients #3, #4, #6, #7 and #8 were in the dining room, all waiting to eat their breakfast. Two bowls of cereal and milk sat on the counter and a plate filled with pancakes and waffles was on the counter near the toaster. At 5:47 AM staff #4 added yogurt and applesauce to the two bowls of cereal and milk on the counter and stirred it up. Staff #4 stated it was for clients #5 and #8 "that got pureed meals." At 5:52 AM staff #4 went into the living room and asked client #2 "Do you want anything else with your cereal? Yogurt or oatmeal? Do you want me to fix you some oatmeal?" Client #2 stated, "Yes" and staff #4 returned to the dining room and began preparing oatmeal.</p> <p>__ Client #2 ate waffles, dried cereal with milk mixed with cooked oatmeal and yogurt for her breakfast with milk, water and grape juice.</p> <p>__ Clients #3, #4, #6 and #7 ate pancakes/waffles and dried cereal for their breakfast with milk, water and grape juice.</p> <p>__ Client #8 ate a mixture of pancakes, cereal, yogurt and applesauce all pureed together.</p> <p>At 6:20 AM staff #4 indicated client #1 would be served the same breakfast of dried/cooked cereal and pancakes as was</p>		<p>substitution guidelines. Staff were retrained on the procedure for proper documentation. Menus and substitution records will be kept on file in manager office for 60 days. How will other residents be identified as having the potential to be affected by the same deficient practice and what corrective action will be taken? At training meeting all staff were trained on dining plans, meal preparation and how to properly make and document substitutions. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur? How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place? Nurse consultant and QIDP will ensure daily meal observations are conducted for 2 weeks after 1/21/14 training to ensure consistency in implementing treatment and dining plans. Assuming competency, the observations will resume to monthly by QIDP or Team Leader. During these observations the substitution list will be reviewed to ensure that proper substitutions and documentation occurs. In addition, the registered dietician for the facility will observe the substitution list for accuracy. She presently observes the meal that occurs during her visit, in addition</p>	

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	<p>offered to clients #2, #3, #4, #6 and #7 and client #5 would be given the same pureed mixture of food that was given to client #8.</p> <p>Review of the facility 12/16/09 Week #1 Fall/Winter Adult menu and the 2/16/11 Food Substitution list on 12/18/13 at 5:50 AM indicated the following food items were to be offered/served to clients #1, #2, #3, #4, #5, #6, #7 and #8 for their breakfast meal on 12/18/13:</p> <p>3/4 cup of orange juice 1 breakfast burrito 1/4 cup of salsa 1 - 2 tablespoons of fat free sour cream 1/4 cup of refried beans 1 cup of water coffee as desired 1 cup of skim or 1/2 % milk</p> <p>The facility Food Substitutions list indicated no specific food substitutions for a breakfast burrito with salsa, sour cream and refried beans.</p> <p>Client #2's record was reviewed on 12/18/13 at 2 PM. Client #2's 9/29/13 Nutritional Assessment from the dietician indicated client #2 was to have a regular diet and single servings. The</p>		to the individual nutritional reviews. She will make an additional notation of substitution list use and documentation on her reports.		

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	<p>dietician indicated client #2 was "moderately obese" and had not met her weight goal and was gaining weight. The dietician indicated "would not want further wt (weight gain)."</p> <p>Client #3's record was reviewed on 12/18/13 at 3 PM. Client #3's 9/29/13 Nutritional Assessment from the dietician indicated client #3 was to have a low fat, low cholesterol, no concentrated sweets diet. The dietician indicated client #3 was "severely obese" and "wt goal not met this year."</p> <p>Client #4's record was reviewed on 12/18/13 at 4 PM. Client #4's 9/29/13 Nutritional Assessment from the dietician indicated client #4 was to have a 1500 calorie, no added salt diet.</p> <p>During interview with staff #4 on 12/18/13 at 5:50 AM, staff #4 stated "I don't know the first thing about making a breakfast burrito and besides that; I don't think we even have any refried beans." When asked about appropriate substitutions, staff #4 stated, "I know there's a list of substitutions there on the frig (refrigerator)." Staff #4 indicated she did not review and/or use the substitution list for the preparation of the breakfast menu.</p>			

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W000481	<p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 12/19/13 at 3 PM indicated the staff were to follow the facility menus and to offer appropriate substitutions when items were not available for the menu preparation.</p> <p>9-3-8(a)</p> <p>483.480(c)(2) MENUS Menus for food actually served must be kept on file for 30 days.</p> <p>Based on observation, record review and interview for 8 of 8 clients living in the group home (clients #1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to ensure the staff documented the substituted menu items of the food actually served to the clients.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/18/13 between 5:20 AM and 8:15 AM. At 5:30 AM two bowls of cereal and milk were sitting on the counter. A plate filled with pancakes and waffles was on the counter near the toaster. At 5:47 AM staff #4 added yogurt and applesauce to the two bowls of cereal and milk on the counter and stirred it up. Staff #4 stated it was for clients #5 and #8 "that got pureed</p>	W000481	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice? New Hope of Indiana reviewed procedures for substitution process. Our procedure is still current best practice and remains appropriate. Staff had previously been trained on the use of the substitution document but had gradually stopped using the tool appropriately. The document was hanging on the refrigerator at time of survey behind the substitution guidelines. Staff were retrained on the procedure for proper documentation. Menus and substitution records will be kept on file in manager office for 60 days. How will other residents be identified as having the potential to be affected by the same deficient practice and what corrective action will be taken? At training meeting all staff were</p>	01/24/2014			

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	<p>meals." At 5:52 AM staff #4 went into the living room and asked client #2 "Do you want anything else with your cereal? Yogurt or oatmeal? Do you want me to fix you some oatmeal?" Client #2 stated, "Yes" and staff #4 returned to the dining room and began preparing oatmeal.</p> <p>__ Client #2 ate waffles, dried cereal with milk mixed with cooked oatmeal and yogurt for her breakfast with milk, water and grape juice.</p> <p>__ Clients #3, #4, #6 and #7 ate pancakes/waffles and dried cereal for their breakfast with milk, water and grape juice.</p> <p>__ Client #8 ate a mixture of pancakes, cereal, yogurt and applesauce all pureed together.</p> <p>At 6:20 AM staff #4 indicated client #1 would be served the same breakfast of dried/cooked cereal and pancakes as was offered to clients #2, #3, #4, #6 and #7 and client #5 would be given the same pureed mixture of food that was given to client #8.</p> <p>Review of the facility 12/16/09 Week #1 Fall/Winter Adult menu and the 2/16/11 Food Substitution list on 12/18/13 at 5:50 AM indicated the following food items were to be offered/served to clients #1, #2, #3, #4, #5, #6, #7 and #8 for their breakfast meal on 12/18/13:</p>		<p>trained on dining plans, meal preparation and how to properly make and document substitutions. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur? How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place? Nurse consultant and QIDP will ensure daily meal observations are conducted for 2 weeks after 1/21/14 training to ensure consistency in implementing treatment and dining plans. Assuming competency, the observations will resume to monthly by QIDP or Team Leader. During these observations the substitution list will be reviewed to ensure that proper substitutions and documentation occurs. In addition, the registered dietician for the facility will observe the substitution list for accuracy. She presently observes the meal that occurs during her visit, in addition to the individual nutritional reviews. She will make an additional notation of substitution list use and documentation on her reports.</p>				

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	<p>3/4 cup of orange juice 1 breakfast burrito 1/4 cup of salsa 1 - 2 tablespoons of fat free sour cream 1/4 cup of refried beans 1 cup of water coffee as desired 1 cup of skim or 1/2 % milk</p> <p>During interview with staff #4 on 12/18/13 at 5:50 AM, staff #4 stated "I don't know the first thing about making a breakfast burrito and besides that; I don't think we even have any refried beans." When asked about appropriate substitutions, staff #4 stated, "I know there's a list of substitutions there on the frig (refrigerator)." Staff #4 indicated she did not review and/or use the substitution list for the preparation of the breakfast meal. When asked where the staff were to document the foods substituted for the meals, staff #4 stated, "I just tell the next shift when they come in. We don't write it down that I know of."</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) and the Group Home Director (GHD) on 12/19/13 at 3 PM indicated the staff were to follow the facility menus and to offer appropriate substitutions when</p>			

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W000488	<p>items were not available for the menu preparation. The GHD indicated the staff were to document foods used for substitution on a facility form used for substitutions. When asked for substitution form for the past 3 months, the GHD stated, "Apparently the staff haven't been documenting it."</p> <p>9-3-8(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation, interview and record review for 4 of 4 sampled clients (#1, #2, #3 and #4) and 4 additional clients (#5, #6, #7 and #8), the facility failed to ensure the clients participated with meal preparation, to ensure the clients were supervised while eating and to ensure the staff followed/implemented the clients' dining plans.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/16/13 between 4:30 PM and 6:30 PM. During this observation clients #1, #2, #3, #4, #5, #6, #7 and #8 were observed eating their evening meal of meatloaf, mashed</p>	W000488	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice? How will other residents be identified as having the potential to be affected by the same deficient practice and what corrective action will be taken? All staff were retrained on the objectives and training opportunities for all individuals. Meal planning and preparation was reviewed with strategies to engage and direct active treatment ideas. All Dining plans were reviewed as well. In addition, the specific dysphagia recommendations in regard to safe eating (setting down utensil, alternating sip and bite) were reviewed. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does</p>	01/24/2014
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	<p>potatoes, a broccoli and cauliflower mix, a slice of bread and mandarin oranges.</p> <p>__At 5:40 PM staff #3 placed clothing protectors on clients #4, #5, #6 and #8.</p> <p>__At 5:45 PM clients #1, #2, #3, #4, #5, #6, #7 and #8 sat at the dining room table waiting on the evening meal to be served while staff #1 and #2 prepared the instant mashed potatoes. Staff 3 placed one slice of bread on client #1's, #2's, #3's, #5's and #7's plates. Client #3 immediately picked up the slice of bread without cutting it and began taking large bites, eating the entire slice of bread. The staff did not redirect client #3 to cut his bread and/or to take smaller bites.</p> <p>__At 5:50 PM staff #3 assisted clients #1, #2, #3 and #4 to put mashed potatoes and then a broccoli/cauliflower mix on their plates. Staff #3 then placed a serving of the broccoli/cauliflower mix onto client #7's plate. Staff #1 pureed client #5's and #8's food and prepared their plates.</p> <p>__At 5:53 PM clients #2 and #8 yelled at client #3 "Stop eating!" Client #1 leaned over her plate and began eating with her fingers, scooping her food. The staff did not redirect client #1 to sit up straight, to take small bites and/or to use her utensils. Staff #1 prepared client #6's plate, took it to the table and placed it in front of client #6. Staff #1 then took client #5's and #8's plates to the table</p>		<p>not recur? How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place? Manager and Team Leader will make daily observations that active treatment opportunities are being offered for the first 2 weeks of correction period. These observations will include those skills relevant to meal preparation and safe eating. Weekly home observations will resume at that point given satisfactory staff progress toward expectations. Monthly case management and goal review will give indication of progress toward goals of gaining independence in leisure interest areas. Dietician will continue to monitor appropriate implementation of menu and dining plans at quarterly observations.</p>	

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	<p>and sat the pre filled plates down in front of the clients. Staff #1 looked at client #3 and stated, "[Client #3], you need to stop eating please." __At 5:55 PM staff #3 placed a tomato sauce on client #2's plate and placed a serving of meat loaf on client #3's plate.</p> <p>During this meal client #1 sat slumped over her plate and scooped her food to her mouth, eating part of her meal with her fingers. The staff did not prompt client #1 to sit up straight, to take smaller bites and/or to use her utensils. Clients #2 and #7 did not use a rocker knife to cut their foods. Clients #3, #7 and #8 ate at a fast pace and took large bites. The staff did not prompt clients #1, #3, #4, #7 and #8 to slow down or to take smaller bites until the meal was almost over. Client #3 was not prompted to put his utensil down or to alternate between liquids and solids. At the beginning of the meal, the staff did not sit down with the clients while they ate their meal as they were too busy serving the clients their food. Once the food was on the table and the clients' portions were on their plates, the staff sat down at the table but the clients had already began eating and the staff failed to prompt the clients to slow down and take smaller bites throughout the meal. Client #5 was in a wheelchair and was</p>			

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	<p>fed his meal by the staff.</p> <p>Observations were conducted at the group home on 12/18/13 between 5:20 AM and 8:15 AM.</p> <p>__ At 5:20 AM there was one staff in the group home with 8 clients. Clients #1 and #5 were still in bed, client #2 sat by herself in the living room and clients #3, #4, #6, #7 and #8 were in the dining room. Client #3 sat in a straight chair against the dining room wall with his arms folded and slightly slumped forward and to the side. Client #4 sat in her seated rolling walker against the island kitchen counter. Client #7 was pouring water into the glasses on the table and clients #6 and #8 were sitting at the dining room table. The table was set with silverware and glasses and two bowls of cereal and milk set on the counter and a plate filled with pancakes and waffles was on the counter near the toaster. After pouring the drinks, client #7 sat down at the dining room table. Staff #4 proceeded in preparing the clients' food for the morning meal.</p> <p>__ At 5:47 AM staff #4 added yogurt and applesauce to the two bowls of cereal and milk on the counter and stirred it up. Staff #4 stated it was for clients #5 and #8 that got pureed meals.</p> <p>__ At 5:52 AM staff #4 went into the living room and asked client #2 "Do you</p>			
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	<p>want anything else with your cereal? Yogurt or oatmeal? Do you want me to fix you some oatmeal?" Client #2 stated, "Yes" and staff #4 returned to the dining room and began preparing oatmeal. Client #4 stated, "I'm hungry. ___At 5:57 AM client #4 stated again, "I'm hungry." Staff #4 placed a clothing protector on client #4 and scooted her up to the table.</p> <p>___At 6:02 AM staff #4 placed a bowl of cereal and milk on the table in front of client #4. Client #4 began eating her cereal. Clients #3, #6, #7 and #8 still sat waiting for breakfast. Client #2 remained in the living room by herself.</p> <p>___At 6:04 AM staff #4 stated "I could go ahead and feed them, but I'm supposed to wait on the 6 AM person because they choke." When asked why #4 was eating and the other clients could not, staff #4 stated to client #4, "Oh, you know you're supposed to eat with your housemates." Staff #4 scooted client #4's bowl away from the client.</p> <p>___At 6:07 AM staff #5 arrived and the clients' plates were prepared. Staff #4 used a rocker knife to cut up client #2's, #3's and #7's waffles/pancakes. Staff #5 cut up client #6's food then placed it on the table in front of client #6. Staff #4 placed a tray with a bowl of cereal in front of client #8. Client #2 was called to come to the dining room for</p>			

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	<p>breakfast.</p> <p>__ By 6:10 AM all clients were served their breakfast and were eating. Client #3 had finished his cereal and picked up his bowl and began drinking from his bowl. Client #3 ate his meal at a fast pace.</p> <p>__ At 6:20 AM clients #3 and #4 had finished their meals and pushed their bowls/plates back to the center of the table. Client #4 stated, "I'm through." Staff #4 stated, "Ok, just relax." Staff #4 stated, "I try to have them stay at the table till everyone is done like a family."</p> <p>__ At 6:30 AM client #6 finished her meal and got up from the table. Client #6 was prompted to take her dishes to the sink. Client #3 got up from the table and took his dishes to the sink.</p> <p>During this morning observation, the clients were not prompted to assist with the preparation of the meal when opportunity was available. The staff did not prompt the clients to take smaller bites and to slow their pace of eating throughout the meal when needed. Client #3 was not prompted to put his utensil down or to alternate between liquids and solids.</p> <p>Client #1's record was reviewed on 12/18/13 at 1 PM. Client #1's dining plan of 9/17/13 indicated client #1 was</p>				

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	<p>to take small bites, less than one teaspoon per intake. The plan indicated the staff were to encourage client #1 to sit up straight during meals.</p> <p>Client #2's record was reviewed on 12/18/13 at 2 PM. Client #2's dining plan of 7/8/13 indicated client #2 used a rocker knife and was to be encouraged to take small bites.</p> <p>Client #3's record was reviewed on 12/18/13 at 3 PM. Client #3's dining plan of 7/8/13 indicated client #3 was to cut his food into one quarter to one half inch pieces, and consume less than one teaspoon per intake. The plan indicated client #3 was to alternate liquids and solids and was to be prompted to put his utensil down between bites.</p> <p>Client #4's record was reviewed on 12/18/13 at 4 PM. Client #4's dining plan of 7/8/13 indicated client #4 was to take less than one teaspoon per intake and to alternate sips of liquids and bites of food.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 12/19/13 at 3 PM indicated the staff were to prompt the clients to assist with meal preparation and provide the clients with training in meal preparation at</p>			

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W009999	<p>every opportunity. The QIDP indicated the staff were to sit with the clients while the clients ate their meal so the staff could monitor the clients for choking issues, implement dining plans and provide an example of family style dining.</p> <p>9-3-8(a)</p> <p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met:</p> <p>460 IAC 9-3-1 Governing Body</p> <p>(b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division: an emergency intervention for the individual resulting from a physical symptom.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview</p>	W009999	<p>All leadership staff were retrained on timely reporting of incidents. This incident was reported upon discovery that report had not been submitted. Overall reporting compliance and timeliness scorecards have improved across all New Hope of Indiana facilities. Group Home Director maintains a quarterly review of timeliness, reporting trends and number of reports made. Quality Assurance Coordinator also tracks all reportable incidents and maintains a spreadsheet of incident which can be analyzed by staff involved, client, home, date, time among others. This oversight of reporting seems to be a isolated incident and occurred over a holiday weekend. The site did follow all other protocols and reported to the nurse on call.</p>	01/24/2014

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	<p>for 1 of 4 sample clients (#4), the facility failed to report to the Bureau of Developmental Disabilities Services (BDDS) regarding an incident requiring client #4 to be taken to an immediate care facility for medical assistance.</p> <p>Findings include:</p> <p>Client #4's record was reviewed on 12/18/13 at 4 PM. Client #4's Progress Note dated 11/29/13 at 9:34 PM indicated client #4 complained of not feeling well prior to the evening meal. The nurse on call and team leader were notified and the staff were instructed to take client #4 to "immediate care." The note indicated client #4 was given medication for an upper respiratory infection (URI). Client #4's nursing notes indicated client #4 was seen 11/29/13 for a "viral URI and high blood pressure."</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 12/19/13 at 3 PM indicated BDDS was to be notified of all reportable incidents within 24 hours of the time of the incident. The QIDP indicated client #4's urgent care should have been reported to BDDS.</p> <p>9-3-1(b)</p>			

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