

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/11/2014
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NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
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W000000	<p>This visit was for a pre-determined full annual recertification and state licensure survey.</p> <p>Dates of Survey: 12/8/14, 12/9/14, 12/10/14 and 12/11/14.</p> <p>Facility Number: 000972 Provider Number: 15G458 AIMS Number: 100244840</p> <p>Surveyor: Keith Briner, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/18/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview for 3 of 4 sampled clients (#2, #3, and #4), and 4 additional clients (#5, #6, #7, and #8), the Governing Body failed to exercise general operating direction over the facility by failing to implement</p>	W000104	<p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice? How will other residents having the potential to be affected by the same deficient practice be</i></p>	01/09/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>policies and procedures which addressed the Elder Justice Act; which requires specific individuals in applicable long term care facilities to report any reasonable suspicion of crimes committed against a resident of that facility; (pursuant to 6703(B)(3) of The Patient Protection and Affordable Care Act of 2010 according to section 1150B of the Social Security Act.)</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 12/8/14 at 12:45 PM. The review indicated the following:</p> <p>-BDDS report dated 4/29/14 indicated, "On Monday, April 28, 2014, it was discovered that the petty cash for the individuals in the [group home] had been removed from the safe. The [TL (Team Leader) #1] made this discovery when reviewing funds. It is undetermined at this time how the safe was breached. The safe has limited access by associates, only a small few (sic) knowing the combination. During this time period, there was change in team leaders for the home. One team leader was training a newer team leader at which point the manual and combination changed hands.</p>		<p><i>identified and what corrective action will be taken?</i> New Hope of Indiana leadership team will review and retrain on reporting guidelines, emphasizing the requirements to remain compliant with the Elder Justice Act. The minimal amount of funds in that were stolen in this incident were immediately replaced and this small quantity was deemed not to warrant police involvement at the time of the incident. <i>What measures will be put into place or what systemic changes will be made to ensure these deficient practices do not recur?</i> How the corrective actions will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place? All future incidents that indicate a suspicion of a crime, regardless of perceived significance or severity, will be reported according the NHI policy and procedure, as well as state and federal requirements.</p>		

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	<p>The QIDP (Qualified Intellectual Disabilities Professional) will conduct an investigation to determine possible cause or action needed. [Client #2] had \$20.00 taken from her petty cash."</p> <p>-BDDS report dated 4/29/14 indicated, "On Monday, April 28, 2014, it was discovered that the petty cash for the individuals in the [group home] had been removed from the safe." The 4/29/14 BDDS report indicated, "[Client #3] had \$50.00 taken from her petty cash."</p> <p>-BDDS report dated 4/29/14 indicated, "On Monday, April 28, 2014, it was discovered that the petty cash for the individuals in the [group home] had been removed from the safe." The 4/29/14 BDDS report indicated, "[Client #4] had \$1.00 taken from his petty cash."</p> <p>-BDDS report dated 4/29/14 indicated, "On Monday, April 28, 2014, it was discovered that the petty cash for the individuals in the [group home] had been removed from the safe." The 4/29/14 BDDS report indicated, "[Client #5] had \$35.00 taken from her petty cash."</p> <p>-BDDS report dated 4/29/14 indicated, "On Monday, April 28, 2014, it was discovered that the petty cash for the individuals in the [group home] had been</p>			

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	<p>removed from the safe." The 4/29/14 BDDS report indicated, "[Client #6] had \$55.00 taken from her petty cash."</p> <p>-BDDS report dated 4/29/14 indicated, "On Monday, April 28, 2014, it was discovered that the petty cash for the individuals in the [group home] had been removed from the safe." The 4/29/14 BDDS report indicated, "[Client #7] had \$40.00 taken from her petty cash."</p> <p>-BDDS report dated 4/29/14 indicated, "On Monday, April 28, 2014, it was discovered that the petty cash for the individuals in the [group home] had been removed from the safe." The 4/29/14 BDDS report indicated, "[Client #8] had \$55.00 taken from her petty cash."</p> <p>The review did not indicate documentation of the alleged theft of clients #2, #3, #4, #5, #6, #7 or #8's personal funds had been reported to the police.</p> <p>AS (Administrative Staff) #1 was interviewed on 12/9/14 at 2:20 PM. AS #1 indicated the 4/28/14 allegation of theft of clients #2, #3, #4, #5, #6, #7 and #8's personal funds had not been reported to the police. AS #1 indicated any reasonable suspicion of a crime committed against a resident should be</p>			

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W000149	<p>reported to the police.</p> <p>9-3-1(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 1 additional client (#7), the facility failed to implement its policy and procedures to prevent financial exploitation for clients #2, #3, #4, #5, #6, #7 and #8, to ensure facility staff immediately reported client #7's allegation of sexual misconduct to the TL (Team Leader) and failed to implement safeguards to prevent further alleged sexual misconduct during the investigation of client #7's allegation of sexual misconduct regarding DSP (Direct Care Staff) #1.</p> <p>Findings include:</p> <p>1. The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 12/8/14 at 12:45 PM. The review indicated the following:</p> <p>-BDDS report dated 4/29/14 indicated, "On Monday, April 28, 2014, it was discovered that the petty cash for the</p>	W000149	<p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice? How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?</i></p> <p>NHI has a system established to safeguard individual's finances. All finances are locked in the home with access by only 2 people. The cash on hand is counted monthly and reconciled with the corresponding cash envelope record and receipts. After this theft, the cash was reconciled more frequently and no further concerns of missing funds have been noted.</p> <p>Director will retrain all day services leadership on the reporting guidelines, including appropriate response and notifications for any and all allegations. Director will include how to ensure proper safeguards are implemented when an allegation is made toward a staff.</p>	01/09/2015
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	<p>individuals in the [group home] had been removed from the safe. The [TL (Team Leader) #1] made this discovery when reviewing funds. It is undetermined at this time how the safe was breached. The safe has limited access by associates, only a small few (sic) knowing the combination. During this time period, there was change in team leaders for the home. One team leader was training a newer team leader at which point the manual and combination changed hands. The QIDP (Qualified Intellectual Disabilities Professional) will conduct an investigation to determine possible cause or action needed. [Client #2] had \$20.00 taken from her petty cash."</p> <p>-BDDS report dated 4/29/14 indicated, "On Monday, April 28, 2014, it was discovered that the petty cash for the individuals in the [group home] had been removed from the safe." The 4/29/14 BDDS report indicated, "[Client #3] had \$50.00 taken from her petty cash."</p> <p>-BDDS report dated 4/29/14 indicated, "On Monday, April 28, 2014, it was discovered that the petty cash for the individuals in the [group home] had been removed from the safe." The 4/29/14 BDDS report indicated, "[Client #4] had \$1.00 taken from his petty cash."</p>		<p>Group Home manager will review all of the above reporting requirements with group home staff.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure these deficient practices do not recur? How the corrective actions will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place?</i></p> <p>Continue to follow NHI Policy on individual's finance management. The QIDP and Team Leader will continue to maintain the locked safe and systematically reconcile all use of funds on a monthly basis. The NHI Quality Assurance team also reviews all financial envelopes monthly as an additional safeguard. All internal and external reportable incidents are documented electronically and tracked for compliance to timely reporting and follow up. Quality Assurance Department and Director will review each internal and external report for procedural compliance. Any further breaches to procedure will be addressed immediately in performance record.</p>	

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	<p>-BDDS report dated 4/29/14 indicated, "On Monday, April 28, 2014, it was discovered that the petty cash for the individuals in the [group home] had been removed from the safe." The 4/29/14 BDDS report indicated, "[Client #5] had \$35.00 taken from her petty cash."</p> <p>-BDDS report dated 4/29/14 indicated, "On Monday, April 28, 2014, it was discovered that the petty cash for the individuals in the [group home] had been removed from the safe." The 4/29/14 BDDS report indicated, "[Client #6] had \$55.00 taken from her petty cash."</p> <p>-BDDS report dated 4/29/14 indicated, "On Monday, April 28, 2014, it was discovered that the petty cash for the individuals in the [group home] had been removed from the safe." The 4/29/14 BDDS report indicated, "[Client #7] had \$40.00 taken from her petty cash."</p> <p>-BDDS report dated 4/29/14 indicated, "On Monday, April 28, 2014, it was discovered that the petty cash for the individuals in the [group home] had been removed from the safe." The 4/29/14 BDDS report indicated, "[Client #8] had \$55.00 taken from her petty cash."</p> <p>2. The facility's BDDS reports and investigations were reviewed on 12/8/14</p>			

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	<p>at 12:45 PM. The review indicated the following:</p> <p>-BDDS report dated 7/15/14 indicated, "On 7/14/14 [client #7] was at her day service program working with staff [DSP #2]. At 3:30 PM, [DSP #1] arrived to drop off an item for another client. [Client #7] informed [DSP #2], 'I don't like him.' [DSP #1] is a regular DSP at [client #7's] group home. After [DSP #1] left [client #7] told [DSP #2] she needed to talk to her. [Client #7] stated that when she was getting up this morning that [DSP #1] was staring at her through the door as she was naked. [DSP #2] told [client #7] that she wanted her to tell [TL #1] what had happened. At that time, [client #7] stated she would like to talk to [TL #1]. As [TL #1] was talking to [client #7], [DSP #1] returned to pick up the clients to return to the group home. [Client #7] became angry and stated, 'What is he doing here?' [TL #1] asked [client #7] what was wrong and [client #7] stated she did not like [DSP #1] and did not want to ride in the van with him. [Client #7] did not repeat her allegation to [TL #1]. [Client #7] did get on the van without incident and did return to the group home. At 3:50 PM, [DSP #2] informed [TL #1] of [client #7's] allegation and [TL #1] informed the QIDP (Qualified Intellectual Disabilities</p>						

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	<p>Professional)."</p> <p>The 7/15/14 BDDS report indicated client #7 made an allegation of sexual misconduct by DSP #1 to DSP #2 while at her day services program. The 7/15/14 BDDS report indicated client #7 was transported from her day services program to her group home with DSP #1 after making an allegation of sexual misconduct against DSP #1. The 7/15/14 BDDS report indicated DSP #2 did not report client #7's allegation of sexual misconduct of DSP #1 to TL #1 or supervisor.</p> <p>QIDP #1 was interviewed on 12/9/14 at 2:20 PM. QIDP #1 indicated client #7 made an allegation to DSP #2 while at the day services program. QIDP #1 indicated client #7 alleged that DSP #1 had been staring at her while she was getting dressed in her bedroom on the morning of 7/14/14. QIDP #1 indicated DSP #1 transported client #7 from her day services program back to her group home after client #7 made an allegation of sexual misconduct against him.</p> <p>AS (Administrative Staff) #1 was interviewed on 12/9/14 at 2:25 PM. AS #1 indicated safeguards should be put in place during the investigation of allegations of sexual misconduct. AS #1</p>			

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	<p>indicated financial exploitation/theft of client funds should be prevented. AS #1 indicated the facility's abuse and neglect policy should be implemented. AS #1 indicated DSP #2 should have reported client #7's allegation of sexual misconduct to her TL.</p> <p>The facility's policy and procedures were reviewed on 12/9/14 at 3:00 PM. The facility's Suspected Abuse policy dated 7/2014 indicated, "Exploitation includes, but is not limited to, the following acts: (1.) Unauthorized use of an individual's services, property or identity; (2.) Theft; (3.) Mismanagement of money or financial assets." The facility's Suspected Abuse policy dated 7/2014 indicated, "If an associate suspects that an individual may be a victim of abuse, neglect or exploitation, the associate is required to contact his/her supervisor or the on-call team leader." The 7/2014 Suspected Abuse policy indicated, "Following all reported incidents of suspected abuse, neglect or exploitation, New Hope will utilize the following procedures: (1.) New Hope will take all immediate steps necessary to protect the victim from any additional abuse, neglect or exploitation, and to insure their safety."</p> <p>9-3-2(a)</p>			

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W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview for 1 of 4 allegations of abuse, neglect and mistreatment reviewed, the facility failed to ensure facility staff immediately reported client #7's allegation of sexual misconduct regarding DSP (Direct Support Professional) #1 to the TL (Team Leader) or facility administrator in accordance with state law.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 12/8/14 at 12:45 PM. The review indicated the following:</p> <p>-BDDS report dated 7/15/14 indicated, "On 7/14/14 [client #7] was at her day service program working with staff [DSP #2]. At 3:30 PM, [DSP #1] arrived to drop off an item for another client. [Client #7] informed [DSP #2], 'I don't like him.' [DSP #1] is a regular DSP at [client #7's] group home. After [DSP #1]</p>	W000153	<p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice? How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?</i></p> <p>Director will retrain all day services leadership on the reporting guidelines, including appropriate response and notifications for any and all allegations. Director will include how to ensure proper safeguards are implemented when an allegation is made toward a staff. Group Home manager will review all of the above reporting requirements with group home staff.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure these deficient practices do not recur? How the corrective actions will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put in place?.</i></p>	01/09/2015

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	<p>left [client #7] told [DSP #2] she needed to talk to her. [Client #7] stated that when she was getting up this morning that [DSP #1] was staring at her through the door as she was naked. [DSP #2] told [client #7] that she wanted her to tell [TL #1] what had happened. At that time, [client #7] stated she would like to talk to [TL #1]. As [TL #1] was talking to [client #7], [DSP #1] returned to pick up the clients to return to the group home. [Client #7] became angry and stated, 'What is he doing here?' [TL #1] asked [client #7] what was wrong and [client #7] stated she did not like [DSP #1] and did not want to ride in the van with him. [Client #7] did not repeat her allegation to [TL #1]. [Client #7] did get on the van without incident and did return to the group home. At 3:50 PM, [DSP #2] informed [TL #1] of [client #7's] allegation and [TL #1] informed the QIDP (Qualified Intellectual Disabilities Professional)."</p> <p>The 7/15/14 BDDS report indicated DSP #2 did not report client #7's allegation of sexual misconduct of DSP #1 to TL #1 or supervisor.</p> <p>QIDP #1 was interviewed on 12/9/14 at 2:20 PM. QIDP #1 indicated client #7 made an allegation to DSP #2 while at the day services program. QIDP #1</p>		All internal and external reportable incidents are documented electronically and tracked for compliance to timely reporting and follow up. Quality Assurance Department and Director will review each internal and external report for procedural compliance. Any further breaches to procedure will be addressed immediately in performance record.				

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W000155	<p>indicated client #7 alleged that DSP #1 had been staring at her while she was getting dressed in her bedroom on the morning of 7/14/14.</p> <p>AS (Administrative Staff) #1 was interviewed on 12/9/14 at 2:25 PM. AS #1 indicated DSP #2 should have reported client #7's allegation of sexual misconduct to her TL.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must prevent further potential abuse while the investigation is in progress. Based on record review and interview for 1 of 4 allegations of abuse, neglect and mistreatment reviewed, the facility failed to implement safeguards to prevent further alleged sexual misconduct during the investigation of client #7's allegation of sexual misconduct regarding DSP (Direct Support Professional) #1.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 12/8/14 at 12:45 PM. The review indicated the following:</p>	W000155	<p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice? How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?</i></p> <p>Director will retrain all day services leadership on the reporting guidelines, including appropriate response and notifications for any and all allegations. Director will include how to ensure proper safeguards are implemented when an allegation is made toward a staff. Group Home manager will review all</p>	01/09/2015

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	-BDDS report dated 7/15/14 indicated, "On 7/14/14 [client #7] was at her day service program working with staff [DSP #2]. At 3:30 PM, [DSP #1] arrived to drop off an item for another client. [Client #7] informed [DSP #2], 'I don't like him.' [DSP #1] is a regular DSP at [client #7's] group home. After [DSP #1] left [client #7] told [DSP #2] she needed to talk to her. [Client #7] stated that when she was getting up this morning that [DSP #1] was staring at her through the door as she was naked. [DSP #2] told [client #7] that she wanted her to tell [TL (Team Leader) #1] what had happened. At that time, [client #7] stated she would like to talk to [TL #1]. As [TL #1] was talking to [client #7], [DSP #1] returned to pick up the clients to return to the group home. [Client #7] became angry and stated, 'What is he doing here?' [TL #1] asked [client #7] what was wrong and [client #7] stated she did not like [DSP #1] and did not want to ride in the van with him. [Client #7] did not repeat her allegation to [TL #1]. [Client #7] did get on the van without incident and did return to the group home. At 3:50 PM, [DSP #2] informed [TL #1] of [client #7's] allegation and [TL #1] informed the QIDP (Qualified Intellectual Disabilities Professional)."		of the above reporting requirements with group home staff. <i>What measures will be put into place or what systemic changes will be made to ensure these deficient practices do not recur? How the corrective actions will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put in place?.</i> All internal and external reportable incidents are documented electronically and tracked for compliance to timely reporting and follow up. Quality Assurance Department and Director will review each internal and external report for procedural compliance. Any further breaches to procedure will be addressed immediately in performance record.	

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W000227	<p>The 7/15/14 BDDS report indicated client #7 made an allegation of sexual misconduct by DSP #1 to DSP #2 while at her day services program. The 7/15/14 BDDS indicated client #7 was transported from her day services program to her group home with DSP #1 after making an allegation of sexual misconduct against DSP #1.</p> <p>QIDP #1 was interviewed on 12/9/14 at 2:20 PM. QIDP #1 indicated client #7 made an allegation to DSP #2 while at the day services program. QIDP #1 indicated client #7 alleged that DSP #1 had been staring at her while she was getting dressed in her bedroom on the morning of 7/14/14. QIDP #1 indicated DSP #1 transported client #7 from her day services program back to her group home after client #7 made an allegation of sexual misconduct against him.</p> <p>AS (Administrative Staff) #1 was interviewed on 12/9/14 at 2:25 PM. AS #1 indicated safeguards should be put in place during the investigation of allegations of sexual misconduct.</p> <p>9-3-2(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the</p>						

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	<p>specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on record review and interview for 2 of 4 sampled clients (#1 and #3), the facility failed to ensure client #1's ISP (Individual Support Plan)/BSP (Behavior Support Plan) included specific objectives to address client #1's resistance/refusals to participate in medical and dental procedures and to ensure client #3's ISP/BSP addressed client #3's picking/scratching behaviors.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 12/9/14 at 12:54 PM. Client #1's Person Centered Meeting form dated 6/11/14 indicated, "5/29/14: [Dentist] unable to complete exam due to refusal and anxiety. Recommendation for exam to be completed under anesthesia." Client #1's Hospital Procedure Note dated 7/11/14 indicated, "Indications for Procedure: The patient, [client #1], is a 28 year old moderately mentally handicapped female who presented to my office with generalized decay. During the examination she proved very anxious and unmanageable. Due to these conditions we elected to do her treatment under general anesthesia." The 7/11/14 Hospital Procedure Note indicated, "[Client #1]</p>	W000227	<p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice? How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?</i></p> <p>BSP/ISP were updated for Client # 1 to address interventions to complete medical appointments. BSP/ISP and High Risk Plans were updated to address Client #3 need for support around self-injurious behavior and picking. All plans will be reviewed with staff to ensure everyone is aware of current practice.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure these deficient practices do not recur? How the corrective actions will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put in place?</i></p> <p>Group Home Director will continue to audit all behavior plans. This medical addendum was missed as Client #1 audit was not yet completed after her admission. Director will audit any new admission chart at 30 days of</p>	01/09/2015			

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	<p>was taken to the OR (Operating Room) and placed in a supine position. [Client #1] was then induced with nitrous oxide (anesthesia), oxygen and evaluate (anesthesia). An IV was then initiated....The patient was then intubated with a... tube." Client #1's BSP dated 7/1/14 and/or ISP dated 6/11/14 did not indicate documentation of a plan of desensitization to support client #1 regarding medical/dental anxiety.</p> <p>LPN (Licensed Practical Nurse) #1 was interviewed on 12/9/14 at 2:15 PM. LPN #1 indicated client #1 was resistant to receiving/participating in routine medical and dental procedures. LPN #1 indicated client #1 required anesthesia to complete her 7/11/14 routine dental procedure.</p> <p>2. Client #3's record was reviewed on 12/9/14 at 8:56 AM. Client #3's Hospital form dated 9/6/13 indicated, "[Client #3] lives in group home. Received radiation at age 13 (1967) to stop menses and has history of non-healing skin ulcers to irradiated areas in the past that took a long time to heal. [Client #3] moved to group home approximately 1 month ago (lived with mother previously) and within a month has developed new breakdown to radiated areas."</p> <p>Client #3's Wound Care Form (WCF)</p>		<p>admission.</p> <p>Nursing Department will flag each of their charts that include a treatment plan that has a PRN or sedation for medical appointments. Behavior Consultants will provide the nursing program with a current copy of each consented medication addendum to treat for medical appointments. Nurses will maintain this within their working medical chart. Nurse Consultant updated the High Risk plan for Client #3 to include use of gloves, positioning and increased bathroom supervision to help reduce the incidents of picking. Picking was also added as a target behavior to her BSP and will be tracked more formally to address any continued concerns.</p>				

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	<p>dated 9/8/14 indicated, "[Client #3] should avoid scratching at area." Client #3's WCF dated 9/8/14 indicated, "[Client #3] should avoid scratching at area." Client #3's Physician's Orders form dated 11/11/14 indicated, "Continue encouraging no scratching." Client #3's Physician's Orders form dated 12/2/14 indicated, "Please encourage no scratching (to) area. Please have [client #3] wear latex gloves when using the bathroom as to protect area from scratching."</p> <p>Client #3's ISP dated 7/14/14 did not indicate documentation of specific supports to address client #3's picking/scratching behaviors. Client #3's BSP dated 5/1/14 did not indicate documentation of picking as a targeted behavior.</p> <p>QIDP (Qualified Intellectual Disability Professional) #1 was interviewed on 12/9/14 at 10:15 AM. QIDP #1 indicated client #3 had radiation sterilization when she was 13 years old in 1967. QIDP #1 indicated client #3 had ongoing radiation skin integrity issues in her buttocks area. QIDP #1 indicated client #3 had an open ulcer wound in her coccyx/buttocks area. QIDP #1 indicated client #3's wound had begun in September 2013 and had not</p>			

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W000268	<p>completely healed. QIDP #1 indicated client #3 had a history of wounds not healing properly due to the radiation treatments she received as a child. QIDP #1 indicated client #3 had skin picking and scratching behaviors. QIDP #1 indicated client #3's skin picking and scratching behaviors had affected the healing of her open ulcer wound. QIDP #1 indicated client #3's ISP/BSP had not been updated to include or address client #3's skin picking and/or scratching behaviors.</p> <p>9-3-4(a)</p> <p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation and interview for 1 additional client (#8), the facility failed to promote client #8's independence, growth and dignity.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/9/14 from 6:15 AM through 8:00 AM. At 7:30 AM, client #8 was laying down on the group home's couch located in the home's common day</p>	W000268	<p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice? How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?</i></p> <p>Staff have purchased pajama pants for Client #3 which provide her with less exposure. In addition, a program goal to maintain her own dignity and privacy will be added to</p>	01/09/2015

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W000331	<p>room/family room area. Client #8, who was female, was dressed in a nightgown which ended 6 inches above her knees. While laying on the couch, client #8's nightgown did not cover her genital area and exposed her incontinence brief. At 7:30 AM, client #4, who was male, sat on the couch next to client #8 who remained in a laying position. Client #4 was seated at client #8's feet and had direct eyesight of client #8's exposed incontinence brief and pelvic region. Client #8 was not encouraged to cover herself or re-position herself on the couch to prevent client #4 from viewing her undergarments and pelvic area.</p> <p>AS (Administrative Staff) #1 was interviewed on 12/9/14 at 2:20 PM. AS #1 indicated client #8 should be encouraged to cover her undergarments and private areas while in the common areas of the home.</p> <p>9-3-5(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 1 of 4 sampled clients (#3), the facility nurse failed to met the health needs of client #3.</p>	W000331	<p>her ISP.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure these deficient practices do not recur? How the corrective actions will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put in place?</i></p> <p>Staff will be retrained on strategies to maintain and preserve the dignity and privacy of all individuals in a communal setting. Team Leader and Manager will conduct weekly observations specific to this concern during the next month to ensure no further concerns continue or develop.</p> <p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice? How will other</i></p>	01/09/2015

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	<p>Findings include:</p> <p>Client #3's record was reviewed on 12/9/14 at 8:56 AM. Client #3's Hospital form dated 9/6/13 indicated, "[Client #3] lives in group home. Received radiation at age 13 (1967) to stop menses and has history of non-healing skin ulcers to irradiated areas in the past that took a long time to heal. [Client #3] moved to group home approximately 1 month ago (lived with mother previously) and within month has developed new breakdown to radiated areas."</p> <p>Client #3's Wound Care Form (WCF) dated 9/6/13 indicated, "Keep weight off affected area/limb. Do not sit for long periods of time."</p> <p>Client #3's WCF dated 4/1/14 indicated, "Reposition frequently (based on patient abilities and wound but at least every 2 hours). Avoid direct pressure to wound site. Limit side lying to 30 degree tilt. Limit head of bed elevation to 30 degrees or less when in bed."</p> <p>Client #3's WCF dated 6/11/14 indicated, "Reposition frequently (based on patient abilities and wound but at least every 2 hours). Avoid direct pressure to wound site. Limit side lying to 30 degree tilt. Limit head of bed elevation to 30 degrees or less when in bed."</p>		<p><i>residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?</i></p> <p>BSP/ISP and High Risk Plans were updated to address Client #3 need for support around self-injurious behavior and picking. All plans will be reviewed with staff to ensure everyone is aware of current practice.</p> <p>Nurse Consultant updated the High Risk plan for Client #3 to include use of gloves, positioning and increased bathroom supervision to help reduce the incidents of picking. Picking was also added as a target behavior to her BSP and will be tracked more formally to address any continued concerns.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure these deficient practices do not recur? How the corrective actions will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put in place?</i></p> <p>Director will continue to review all High Risk plans and conduct monthly random chart audits. Any further missing information on risk plans will be addressed immediately with respective nurse consultant.</p>	

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	<p>Client #3's WCF dated 8/20/14 indicated, "Reposition frequently (based on patient abilities and wound but at least every 2 hours). Avoid direct pressure to wound site. Limit side lying to 30 degree tilt. Limit head of bed elevation to 30 degrees or less when in bed." The 8/20/14 WCF indicated, "[Client #3] should avoid scratching at area."</p> <p>Client #3's WCF dated 9/8/14 indicated, "[Client #3] should avoid scratching at area. The 9/8/14 WCF indicated, "Keep weight off affected area/limb- avoid pressure to area. Reposition frequently."</p> <p>Client #3's Physician's Orders form dated 11/11/14 indicated, "Continue encouraging no scratching.</p> <p>Client #3's Physician's Orders form dated 12/2/14 indicated, "Please encourage no scratching (to) area. Please have [client #3] wear latex gloves when using the bathroom as to protect area from scratching."</p> <p>Client #3's Skin Integrity Plan dated 9/22/14 did not indicate documentation of client #3's 4/1/14, 6/11/14, 8/20/14 and 9/8/14 recommendations for repositioning, how staff were to monitor client #3 during toileting to encourage no scratching and did not indicate client #3's 12/2/14 recommendation to wear latex gloves when using the bathroom.</p>			

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W000460	<p>LPN (Licensed Practical Nurse) #1 was interviewed on 12/9/14 at 2:15 PM. LPN #1 indicated client #3 had an open ulcer in her buttocks area. LPN #1 indicated client #3's skin integrity plan was not updated to include client #3's repositioning, bathroom/toileting monitoring and use of latex gloves recommendations.</p> <p>9-3-6(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. Based on observation, record review and interview for 1 of 4 sampled clients (#3), the facility failed to ensure client #3's food allergy diet was followed.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/9/14 from 6:15 AM through 8:00 AM. At 7:15 AM, DSP (Direct Support Professional) #3 stated, "I brought some hot chocolate in from home for you guys." DSP #3 prepared a serving of hot chocolate for client #3. Client #3 drank a cup of hot chocolate with her peers.</p>	W000460	<p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice? How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?</i></p> <p>Listed allergies for Client #3 were reviewed with her physician and reduced to a category of "intolerance to..." Staff will be trained to avoid allergies and intolerant items for all individuals. Allergies and intolerant foods were reviewed and included on all physician orders.</p>	01/09/2015

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	<p>Client #3's record was reviewed on 12/9/14 at 8:56 AM. Client #3's Physician's Orders Form dated 11/23/14 indicated, "Diet Ancillary: Allergic to regular milk, chocolate...."</p> <p>LPN (Licensed Practical Nurse) #1 was interviewed on 12/9/14 at 2:15 PM. LPN #1 indicated client #3's Physician's Orders dated 11/23/14 listed chocolate as a food allergy for client #3. LPN #1 indicated client #3 should not have hot chocolate.</p> <p>9-3-8(a)</p>		<p><i>What measures will be put into place or what systemic changes will be made to ensure these deficient practices do not recur? How the corrective actions will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put in place?</i></p> <p>Director will continue to complete random monthly nursing chart audits in which the physician orders are reviewed.</p>				