

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G522	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/22/2015
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NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 10264 N COLLEGE INDIANAPOLIS, IN 46280
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W 000 Bldg. 00	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: 4/20/15, 4/21/15 and 4/22/15</p> <p>Facility Number: 001036 Provider Number: 15G522 AIMS Number: 100245250</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 000		
W 149 Bldg. 00	<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 (#5), the facility failed to implement its policy and procedures to prevent neglect of client #5 regarding repeated falls during transfers from her wheelchair and the facility failed to develop and implement effective corrective measures to prevent client #5 from falling during transfers from her wheelchair.</p> <p>Findings include:</p>	W 149	<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? All staff were retrained on the proper transferring techniques for this individual. She is fairly independent in transfers, therefore, the support to her is more likely to vary based on her spasticity needs. A specific</i></p>	05/15/2015

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>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 4/20/15 at 1:30 PM. The review indicated the following:</p> <p>-BDDS report dated 10/21/14 indicated client #5 sustained a dislocated knee while being assisted transfer from her wheelchair to the facility van.</p> <p>-Investigation dated 10/21/14 indicated staff #1 failed to implement client #5's transfer/fall risk plan. The 10/21/14 investigation indicated staff #1 was suspended during the investigation, was retrained on the implementation of client #5's transfer/fall risk plan and the van seating was changed to ensure client #5 utilized the wheelchair lift and not manual transfers to board the van.</p> <p>-IR (Incident Report) dated 1/16/15 indicated, "[Staff #2] heard [client #5] fall while transferring from her wheelchair to the shower chair from outside the bathroom door; [staff #2] heard [client #5] yell that she couldn't get up and she began to cry. Other staff was in the bathroom with [client #5]. [Staff #3]/other staff, shut the door and assisted [client #5] back into the chair. [Staff #2] checked on [client #5] after her shower, she stated she fell on her bottom but</p>		<p>transfer plan was developed and all staff were trained on 4/15/15, shortly after the IDT had identified the need to address. QIDP and Team Leader also completed an environmental scan of bathrooms and identified that an additional grab bar will assist her as well. This is to be installed in the next few days. All fall plans for all other individuals were reviewed. No other transfer concerns were noted in this review. <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> All Group Home Leadership reviewed the deficiency and expectations to respond to incident trends. Team Leader will observe staff over the next 30 days to ensure that all staff are consistent with the transfer protocol specific to her. Any further falls in the facility for anyone will be reviewed immediately. In addition to the standing systems of notification and review, New Hope of Indiana has developed an incident review committee who will meet monthly to review all incidents and ensure follow up is ongoing, trends are identified and systems reviewed. The facility will continue ongoing observations during onsite presence. The Team Leader is</p>	

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	<p>didn't hurt her knee and [staff #2] completed a body check. A dark blue/purple colored bruise was found on her right hip...."</p> <p>-IR dated 2/4/15 indicated, "[Client #5] was attempting to transfer from her wheelchair to the recliner when her left knee buckled and she went down to one knee. Staff assisted her and completed a body check and specifically a left knee check. There were no marks or injuries noted at this time." The 2/4/15 IR indicated staff were retrained regarding stand by assistance while transferring.</p> <p>-IR dated 3/21/15 indicated, "[Client #5] was transferring from toilet to wheelchair. Her buttocks just slipped from her chair and she fell on her buttocks without injury." The 3/21/15 IR indicated, "All direct support staff are to make sure that they are present when individuals are transferring and that there is nothing standing in the way of them and the individual, such as wheelchairs, shower chairs, etc., while individuals are transferring to be of assistance in the event of a fall. All individuals are to where (sic) shoes when up and while transferring. A request for an additional grab bar has been asked to be installed in</p>		assigned to this home solely and will be able to observe this at minimum monthly after she ensures correction and competence have been established.		

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	<p>the front bathroom for assistance with transferring during showers."</p> <p>-IR dated 3/26/15 indicated client #5 slid down to the floor while transferring from her wheelchair. The 3/26/15 IR indicated no injury occurred from this fall.</p> <p>Client #5's Transfer Guidelines to Prevent Falls (TGPF) form dated 4/14/15 was reviewed on 4/20/15 at 1:30 PM. Client #5's TGPF form dated 4/14/15 indicated, "There have been several falls (many without injury), over the last several weeks. This, in my opinion, is due to associates not being properly placed when working with the individuals. At the monthly IDT (Interdisciplinary Team Meeting) on Tuesday, 4/14/15, a training was conducted on how to assist individuals when they are transferring from their wheelchairs to and from the toilet and shower chair."</p> <p>TL (Team Leader) #1 was interviewed on 4/21/15 at 1:15 PM. TL #1 indicated client #5 had falls while transferring on 10/21/14, 1/16/15, 2/4/15, 3/21/15 and 3/26/15. TL #1 indicated staff working with client #5 had been retrained on her transfer protocol and fall risk plans after each incident. TL #1 indicated client #5's seating arrangement on the facility van</p>			
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W 157 Bldg. 00	<p>and in the group home was modified as well as additional grab bars installed in the bathroom to assist with transfers.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 4/21/15 at 1:20 PM. QIDP #1 indicated the facility's abuse and neglect policy should be implemented and corrective measures to prevent recurrence of client #5's falls should be developed and implemented.</p> <p>The facility's Suspected Abuse policy dated 1/2015 was reviewed on 4/22/15 at 9:43 AM. The 1/2015 Suspected Abuse policy indicated, "Neglect is a practice that denies an individual any of the following without a physician's order: the repeated failure of a caregiver to provide supervision, training, appropriate care and the basic necessities of life...."</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 5 of 7 incidents of falls reviewed, the facility failed to develop and implement effective corrective actions to prevent</p>	W 157	<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</i></p>	05/15/2015

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	<p>client #5 from falling during transfers from her wheelchair.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 4/20/15 at 1:30 PM. The review indicated the following:</p> <p>-BDDS report dated 10/21/14 indicated client #5 sustained a dislocated knee while being assisted transfer from her wheelchair to the facility van.</p> <p>-Investigation dated 10/21/14 indicated staff #1 failed to implement client #5's transfer/fall risk plan. The 10/21/14 investigation indicated staff #1 was suspended during the investigation, was retrained on the implementation of client #5's transfer/fall risk plan and the van seating was changed to ensure client #5 utilized the wheelchair lift and not manual transfers to board the van.</p> <p>-IR (Incident Report) dated 1/16/15 indicated, "[Staff #2] heard [client #5] fall while transferring from her wheelchair to the shower chair from outside the bathroom door; [staff #2] heard [client #5] yell that she couldn't get up and she began to cry. Other staff was</p>		<p><i>potential to be affected by the same deficient practice be identified and what corrective action will be taken? All staff were retrained on the proper transferring techniques for this individual. She is fairly independent in transfers, therefore, the support to her is more likely to vary based on her spasticity needs. A specific transfer plan was developed and all staff were trained on 4/15/15, shortly after the IDT had identified the need to address. QIDP and Team Leader also completed an environmental scan of bathrooms and identified that an additional grab bar will assist her as well. This is to be installed in the next few days. All fall plans for all other individuals were reviewed. No other transfer concerns were noted in this review. 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? Team Leader will observe staff over the next 30 days to ensure that all staff are consistent with the transfer protocol specific to her. Any further falls in the facility for anyone will be reviewed immediately. In addition to the standing systems of notification and review, New Hope of Indiana</i></p>	

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	<p>in the bathroom with [client #5]. [Staff #3]/other staff, shut the door and assisted [client #5] back into the chair. [Staff #2] checked on [client #5] after her shower, she stated she fell on her bottom but didn't hurt her knee and [staff #2] completed a body check. A dark blue/purple colored bruise was found on her right hip...."</p> <p>-IR dated 2/4/15 indicated, "[Client #5] was attempting to transfer from her wheelchair to the recliner when her left knee buckled and she went down to one knee. Staff assisted her and completed a body check and specifically a left knee check. There were no marks or injuries noted at this time." The 2/4/15 IR indicated staff were retrained regarding stand by assistance while transferring.</p> <p>-IR dated 3/21/15 indicated, "[Client #5] was transferring from toilet to wheelchair. Her buttocks just slipped from her chair and she fell on her buttocks without injury." The 3/21/15 IR indicated, "All direct support staff are to make sure that they are present when individuals are transferring and that there is nothing standing in the way of them and the individual, such as wheelchairs, shower chairs, etc., while individuals are</p>		<p>has developed an incident review committee who will meet monthly to review all incidents and ensure follow up is ongoing, trends are identified and systems reviewed. The facility will continue ongoing observations during onsite presence. The Team Leader is assigned to this home solely and will be able to observe this at minimum monthly after she ensures correction and competence have been established. Observations will be documented in electronic documentation system in monthly case management summary.</p>		

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	<p>transferring to be of assistance in the event of a fall. All individuals are to where (sic) shoes when up and while transferring. A request for an additional grab bar has been asked to be installed in the front bathroom for assistance with transferring during showers."</p> <p>-IR dated 3/26/15 indicated client #5 slid down to the floor while transferring from her wheelchair. The 3/26/15 IR indicated no injury occurred from this fall.</p> <p>Client #5's Transfer Guidelines to Prevent Falls (TGPF) form dated 4/14/15 was reviewed on 4/20/15 at 1:30 PM. Client #5's TGPF form dated 4/14/15 indicated, "There have been several falls (many without injury), over the last several weeks. This, in my opinion, is due to associates not being properly placed when working with the individuals. At the monthly IDT (Interdisciplinary Team Meeting) on Tuesday, 4/14/15, a training was conducted on how to assist individuals when they are transferring from their wheelchairs to and from the toilet and shower chair."</p> <p>TL (Team Leader) #1 was interviewed on 4/21/15 at 1:15 PM. TL #1 indicated client #5 had falls while transferring on 10/21/14, 1/16/15, 2/4/15, 3/21/15 and</p>			

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W 159 Bldg. 00	<p>3/26/15. TL #1 indicated staff working with client #5 had been retrained on her transfer protocol and fall risk plans after each incident. TL #1 indicated client #5's seating arrangement on the facility van and in the group home was modified as well as additional grab bars installed in the bathroom to assist with transfers.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 4/21/15 at 1:20 PM. QIDP #1 indicated corrective measures to prevent recurrence of client #5's falls should be developed and implemented.</p> <p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview for 1 of 4 sampled clients (#2), the QIDP (Qualified Intellectual Disabilities Professional) failed to integrate, coordinate and monitor client #2's active treatment program by failing to convene the IDT (Interdisciplinary Team) to assess if client #2 needed additional</p>	W 159	<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? Team Leader will reassess the process</i></p>	05/15/2015

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	<p>supports or training to assist her to achieve improved OH (Oral Hygiene).</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 4/21/15 at 10:30 AM. Client #2's Dental Consultation (DC) forms indicated the following:</p> <p>-DC dated 12/4/14 indicated, "Soft Tissue: Inflamed, upper and lower, front and back. Tongue: Coated. OH: Poor."</p> <p>-DC dated 5/28/14 indicated, "Soft Tissue: Inflamed, upper and lower, front and back. OH: Poor."</p> <p>-DC dated 9/25/13 indicated, "OH: Horrible. Additional Findings: Appears that no OH is being done daily. Plaque, calculus and food debris present."</p> <p>Client #2's Nutritional Assessment form dated 12/8/14 indicated, "Nutrition Concerns: potential for choking, history of poor/horrible dental hygiene."</p> <p>Client #2's ISP (Individual Support Plan) dated 12/22/14 indicated, "Other recommendations: (b.) Check mouth after each time she eats to check for pocketing of food." The 12/22/14 ISP indicated, "(4.) OH: see personal care sheet." Client</p>		<p>for tooth brushing for this individual. She is blind, and tends to bite down on the toothbrush while staff are physically assisting her. There was an additional tooth brushing time added to her daily routine and toothette sponges will be added to supplement the tooth brushing efficacy. This individual also has a dental appointment scheduled for June 4th. The additional steps will be completed until that June appointment at which time the attempts will be reevaluated. An additional goal to carry her plate to the table was implemented to further engage her in the mealtime and preparation experience. <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> Team Leader will observe meals and tooth brushing to ensure that the corrective steps are effective and staff are completing the tasks as requested. Team Leader will complete these observations at minimum 2 times per week over the next month. After the initial observation period ensures compliance and competence in delivery, the Team Leader will continue to observe meals and care during her weekly presence in the home. Observations will be</p>	

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	<p>#2's ISP dated 12/22/14 did not indicate documentation of a formal OH goal.</p> <p>Client #2's Personal Care Sheet regarding OH for March 2015 and April 2015 indicated staff had documented client #2's completion of brushing her teeth after dinner and before bed 100% of the time for both months.</p> <p>Client #2's record did not indicate documentation of IDT review or recommendations to assist client #2 achieve improved OH.</p> <p>TL (Team Leader) #1 was interviewed on 4/21/15 at 1:15 PM. TL #1 indicated client #2 had an informal care plan which included staff ensuring client #2 brushed her teeth twice daily. When asked if the IDT had reconciled the documentation of client #2's toothbrushing with her poor dental hygiene reports from the dentist, TL #1 stated, "I looked at it and observed staff assisting and making sure she brushed her teeth. The issue is that she doesn't seem to understand the concept of opening her mouth and keeping it open for brushing. She's not resistant but she clamps her teeth down on the brush." TL #1 indicated there was not documentation of IDT review or assessment of client #2's OH needs.</p>		documented at least monthly in an anecdotal for staff observed.		

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W 488 Bldg. 00	<p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 4/21/15 at 1:20 PM. QIDP #1 indicated there was not documentation of IDT review or assessment of client #2's OH needs.</p> <p>9-3-3(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, record review and interview for 1 of 4 sampled clients (#2), the facility failed to ensure client #2 participated in all aspects of meal preparation to the extent of her capabilities.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 4/20/15 from 3:24 PM through 5:15 PM. TL #1, staff #3 and #4 began preparing the evening meal which consisted of cooked cabbage, potatoes and ham at 4:15 PM. At 4:45 PM, staff #4 used a food processor to puree client #2's meal. Staff #4 pureed the meal, then placed the pureed food on a divided plate and placed client #2's food, drink and</p>	W 488	<p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice? How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? An additional goal to carry her plate to the table was implemented to further engage her in the mealtime and preparation experience. 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? Team Leader will observe meals to ensure staff are completing the</i></p>	05/15/2015

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	<p>silverware on the table in front of client #2. Client #2 was not encouraged to assist with the meal preparation, to serve herself or to place her plate/utensils in the sink after her meal.</p> <p>Observations were conducted at the group home on 4/21/15 from 6:45 AM through 8:30 AM. At 7:20 AM, staff #5 prepared and pureed client #2's portion of oatmeal, scrambled eggs and yogurt on a divided plate. Staff #5 then placed client #2's food, silverware and drink on the table in front of client #2. Client #2 was not encouraged to assist with the meal preparation, to serve herself or to place her plate/utensils in the sink after her meal.</p> <p>Client #2's record was reviewed on 4/21/15 at 10:30 AM. Client #2's ISP (Individual Support Plan) dated 12/22/14 indicated client #2 was able to assist prepare a meal with prompts and hand over hand assistance.</p> <p>TL (Team Leader) #1 was interviewed on 4/21/15 at 1:15 PM. TL #1 indicated client #2 had previously had a formal goal to assist with meal preparation. TL #1 indicated client #2 had achieved the goal to assist with meal preparation. TL #1 indicated the facility should continue to informally offer client #2 the</p>		<p>tasks as requested. Team Leader will complete these observations at minimum 2 times per week over the next month. After the initial observation period ensures compliance and competence in delivery, the Team Leader will continue to observe meals and care during her weekly presence in the home. Observations will be documented at least monthly in an anecdotal for staff observed.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/28/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G522	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/22/2015
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	opportunity to participate in meal preparation to maintain her skills. 9-3-8(a)				