

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G545	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/02/2014
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NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 9001 N HOLLIDAY DR INDIANAPOLIS, IN 46260
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: 4/29/14, 4/30/14, 5/1/14 and 5/2/14.</p> <p>Facility Number: 001059 Provider Number: 15G545 AIMS Number: 100245370</p> <p>Surveyor: Keith Briner, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 5/9/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000189	<p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on observation, record review and interview for 1 of 4 sampled clients (#2) plus 2 additional clients (#5 and #6), the facility failed to ensure staff administered clients #2, #5 and #6's medications in an upright posture/position.</p>	W000189	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice? Staff training procedures include 40 hour orientation, which includes Core A and B Medication Administration curriculum. In</i></p>	05/23/2014

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

TITLE

(X6) DATE

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

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	<p>Findings include:</p> <p>Observations were conducted at the group home on 4/29/14 from 4:05 PM through 5:30 PM. Clients #2, #5 and #6 were observed throughout the observation period. Clients #2, #5 and #6 were non ambulatory in that they did not independently walk and utilized wheelchairs to move through the group home.</p> <p>Observations were conducted at the group home on 4/30/14 from 6:00 AM through 8:15 AM. At 6:40 AM, DSP (Direct Support Professional) #1 prepared client #6's 7:00 AM medications by removing the pharmacy pre-packaged medications from the medication packet and placed the medications into a plastic cup. DSP #1 then mixed client #6's medications with applesauce and entered client #6's personal bedroom. DSP #1 approached client #6, who was lying on his stomach in his bed, and stated, "It's time for your medication." DSP #1 utilized a plastic spoon to scoop the medication and applesauce from the plastic cup to client #6's mouth while client #6 was lying on his stomach in his bed. DSP #1 fed client #6 the applesauce and medications.</p> <p>At 6:48 AM, DSP #1 prepared client #2's</p>		<p>addition, staff participate in an additional 40 hour training on site, including medication administration and client specific training on risk plans including dysphagia/aspiration. This procedure is not consistent with the expectations or what is trained. All staff will attend mandatory training on 5/9/14. Training will review proper medication administration procedures. Training will be completed by the RN for the group home and include a medication administration competency check. Training will also include securing medications and a review of all medication administration goals and the appropriate times to provide this training. In addition, all dining plans and aspiration/choking risks were reviewed. All medications will be reviewed to ensure that medication administration times avoid times in which clients have not yet risen for the day. <i>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</i> Training will include medication administration and goals for all residents living in the home. All staff will pass the competency test in order to continue to administer medications. Any staff not showing competency during this evaluation will receive further retraining prior to passing any</p>				

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	<p>7:00 AM medications by removing the pharmacy pre-packaged medications from the medication packet and placed the medications into a plastic cup. DSP #1 mixed client #2's medications with applesauce and then entered client #2's personal bedroom to administer the medications. Client #2 was lying on her back in her bed. DSP #1 raised the head portion of client #2's adjustable hospital bed to raise client #2's head and body less than 4 inches. Client #2 was not in an upright (90 degree) position. DSP #1 utilized a plastic spoon to scoop the medication and applesauce from the plastic cup to client #2's mouth while client #2 was lying on her back in her bed.</p> <p>At 7:00 AM, DSP #1 prepared client #5's 7:00 AM medications by removing the pharmacy pre-packaged medications from the medication packet and placed the medications into a plastic cup. DSP #1 then mixed client #5's medications with applesauce and entered client #5's personal bedroom to administer the medications. Client #5 was lying on her back in her bed. Client #5 was not in an upright (90 degree) position. DSP #1 then utilized a plastic spoon to scoop the medication and applesauce from the plastic cup to client #5's mouth while client #5 was lying on her back in her</p>		<p>further medications. All staff will demonstrate proper implementation of goals during the training as well. <i>What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur? How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</i> Nurse Consultant, Team Leader and Manager will continue to provide onsite observations of the medication administration procedures being used. These observations will be completed daily for 1 week after the 5/9/14 training to ensure staff continue to utilize proper procedures. After that week of observations, weekly observations will occur for 4 weeks. Assuming all competency returns to standard, the nurse consultant will resume monthly observations. New Hope of Indiana continues to have systematic response to medication errors. All staff will receive a copy of those procedures in scheduled staff meetings 5/13/14 and 5/14/14. Procedural response to all med errors is nurse retraining and supervisory follow up in respect to disciplinary actions. A coaching then expectation approach is followed. See attached Medication Error Procedures for details. No revision to the</p>	

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	<p>bed.</p> <p>1. Client #2's record was reviewed on 4/30/14 at 10:44 AM. Client #2's ISP (Individual Support Plan) dated 4/23/14 indicated client #2 was not able to independently reposition herself in her wheelchair or in her bed. Client #2's ISP dated 4/23/14 indicated client #2 utilized a hospital bed.</p> <p>Client #2's Physician's Order Form (POF) dated 3/26/14 indicated client #2's diagnoses included, but were not limited to, Arthritis, Rheumatoid Arthritis. Client #2's POF dated 3/26/14 indicated, "Mechanical soft diet with chopped meat with nectar thick liquids."</p> <p>Client #2's Aspiration Prevention Plan (APP) dated 1/9/14 indicated client #2 had a history of choking. Client #2's APP indicated, "Staff will ensure client sits up during all feedings."</p> <p>2. Client #5's record was reviewed on 4/30/14 at 7:55 AM. Client #5's ISP dated 12/11/13 indicated client #5's diagnoses included, but were not limited to, Profound Mental Retardation and Cerebral Palsy/Spasticity. Client #5's ISP dated 4/30/14 indicated client #5 utilized a manual propel wheel chair. Client #5's ISP dated 4/30/14 indicated, "Diet Order, Pureed.... (1.) One tablespoon per swallow. Monitor for</p>		<p>existing NHI medication errors procedure is found necessary. New Hope of Indiana Quality Assurance Department and Group Home Director track all medication errors. Oversight is given to trends and concerns. Medication error rate for this home has dropped by 50% over the past year due to increased oversight and training.</p>	

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	<p>chewing/swallowing." Client #5's ISP indicated client #5 had a High Risk Plan regarding dysphasia/aspiration.</p> <p>3. Client #6's POF dated 3/26/14 was reviewed on 5/1/14 at 5:36 PM. Client #6's diagnoses included, but were not limited to, Cerebral Palsy, Spasticity, Arthritis, Osteoarthritis and Mild Carotid Arteriosclerosis. Client #6's POF dated 3/26/14 indicated client #6 was on a mechanical soft diet with nectar thick liquids.</p> <p>QIDP #1 (Qualified Intellectual Disabilities Professional) was interviewed on 4/30/14 at 12:30 PM. QIDP #1 indicated clients #2, #5 and #6 should be administered medications in an upright position. QIDP #1 indicated clients #2, #5 and #6 had special dietary orders due to the risk of dysphasia. QIDP #1 indicated staff should be retrained regarding medication administration.</p> <p>LPN (Licensed Practical Nurse) #1 was interviewed on 4/30/14 at 2:20 PM. LPN #1 indicated facility staff should administer medications to clients in an upright position. LPN #1 indicated clients #2, #5 and #6 had high risk plans regarding aspiration risks and should not receive their medications while lying down in their beds.</p>						

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W000249	<p>9-3-3(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.</p> <p>Based on observation, record review and interview for 2 of 4 sampled clients (#2 and #4) plus 3 additional clients (#5, #6 and #8), the facility failed to provide clients #2, #4, #5, #6 and #8 with active treatment during formal opportunities and informal opportunities to support the clients' achievement of identified ISP (Individual Support Plan) objectives.</p> <p>Findings include</p> <p>Observations were conducted at the facility on 4/30/14 from 6:00 AM through 8:15 AM. At 6:30 AM, DSP (Direct Support Professional) #1 began the group home's morning medication administration. At 6:30 AM, DSP #1 entered the medication administration office and prepared client #4's 7:00 AM medications by removing the pharmacy pre-packaged medications from the medication packet and placed the</p>	W000249	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice? All staff will attend mandatory training on 5/9/14. Training will review proper medication administration procedures. Training will be completed by the RN for the group home and include a medication administration competency check. Training will also include a review of all medication administration goals and the appropriate times to provide this training. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Training will include medication administration and goals for all residents living in the home. All staff will pass the competency test in order to continue to administer medications. Any staff not showing competency during this</i></p>	05/23/2014

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	<p>medications into a plastic cup. DSP #1 then mixed client #4's medications with applesauce and then entered client #4's personal bedroom. DSP #1 did not encourage client #4 to participate in the administration of his medications.</p> <p>At 6:40 AM, DSP #1 prepared client #6's 7:00 AM medications by removing the pharmacy pre-packaged medications from the medication packet and placed the medications into a plastic cup. DSP #1 then mixed client #6's medications with applesauce and then entered client #6's personal bedroom. DSP #1 utilized a plastic spoon to scoop the medication and applesauce from the plastic cup to client #6's mouth. DSP #1 fed client #6 the applesauce and medications. DSP #1 did not encourage client #6 to participate in the administration of his medications.</p> <p>At 6:48 AM, DSP #1 prepared client #2's 7:00 AM medications by removing the pharmacy pre-packaged medications from the medication packet and placed the medications into a plastic cup. DSP #1 then mixed client #2's medications with applesauce and then entered client #2's personal bedroom to administer the medications. DSP #1 utilized a plastic spoon to scoop the medication and applesauce from the plastic cup to client #2's mouth. DSP #1 fed client #2 the</p>		<p>evaluation will receive further retraining prior to passing any further medications. All staff will demonstrate proper implementation of goals during the training as well. <i>What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur? How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</i> Nurse Consultant, Team Leader and Manager will continue to provide onsite observations of the medication administration procedures being used. These observations will be completed daily for 1 week after the 5/9/14 training to ensure staff continue to utilize proper procedures. After that week of observations, weekly observations will occur for 4 weeks. Assuming all competency returns to standard, the nurse consultant will resume monthly observations. New Hope of Indiana continues to have systematic response to medication errors. All staff will receive a copy of those procedures in scheduled staff meetings 5/13/14 and 5/14/14. Procedural response to all med errors is nurse retraining and supervisory follow up in respect to disciplinary actions. A coaching then expectation approach is followed. See attached</p>	

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	<p>applesauce and medications. DSP #1 did not encourage client #2 to participate in the administration of her medications.</p> <p>At 7:00 AM, DSP #1 prepared client #5's 7:00 AM medications by removing the pharmacy pre-packaged medications from the medication packet and placed the medications into a plastic cup. DSP #1 then mixed client #5's medications with applesauce and then entered client #5's personal bedroom to administer the medications. DSP #1 utilized a plastic spoon to scoop the medication and applesauce from the plastic cup to client #5's mouth. DSP #1 fed client #5 the applesauce and medications. DSP #1 did not encourage client #5 to participate in the administration of her medications.</p> <p>At 7:05 AM, DSP #1 prepared client #8's 7:00 AM medications by removing the pharmacy pre-packaged medications from the medication packet and placed the medications into a plastic cup. DSP #1 then mixed client #8's medications with applesauce and then entered client #8's personal bedroom to administer the medications. DSP #1 utilized a plastic spoon to scoop the medication and applesauce from the plastic cup to client #8's mouth. DSP #1 fed client #8 the applesauce and medications. DSP #1 did not encourage client #8 to participate in</p>		<p>Medication Error Procedures for details. No revision to the existing NHI medication errors procedure is found necessary. New Hope of Indiana Quality Assurance Department and Group Home Director track all medication errors. Oversight is given to trends and concerns. Medication error rate for this home has dropped by 50% over the past year due to increased training and oversight, as well as packaging and administration changes.</p>	

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	<p>the administration of her medications.</p> <p>1. Client #2's record was reviewed on 4/30/14 at 10:44 AM. Client #2's ISP dated 4/23/14 indicated client #2 should "Increase self knowledge about medications and needs." Client #2's ISP dated 4/23/14 indicated, "State reason for VNS (Vagus Nerve Stimulation) with 3 verbal cues."</p> <p>2. Client #4's record was reviewed on 4/30/14 at 9:42 AM. Client #4's ISP dated 6/25/13 indicated, "Dependent upon staff and... for all aspects of medical care." The 6/25/13 ISP indicated, "Will get spoon to take medications with..."</p> <p>3. Client #5's record was reviewed on 4/30/14 at 7:55 AM. Client #5's ISP goal data sheet dated 12/1/13 indicated client #5's should get a spoon for her medications.</p> <p>4. Client #6's record was reviewed on 4/30/14 at 7:55 AM. Client #6's ISP goal data sheet dated 4/22/14 indicated client #6 should get his own cup to take his medications.</p> <p>5. Client #8's record was reviewed on 4/30/14 at 7:55 AM. Client #8's ISP goal data sheet dated 12/1/13 indicated client #8 should come to the medication office</p>				

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W000368	<p>for her PM medications.</p> <p>DSP #1 was interviewed on 4/30/14 at 7:15 AM. When asked if clients #2, #4, #5, #6 or #8 had medication administration goals, DSP #1 stated, "No. No, morning medication goals. Medication goals are done in the evening." When asked if clients #2, #4, #5, #6 or #8 should assist with the administration of their morning medications, DSP #1 stated, "No."</p> <p>QIDP #1 (Qualified Intellectual Disabilities Professional) was interviewed on 4/30/14 at 12:30 PM. QIDP #1 indicated active treatment should occur at every available opportunity. QIDP #1 indicated DSP #1 should implement informal medication administration training at each opportunity to maintain skills and support the clients' achieve their ISP objectives.</p> <p>9-3-4(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 3 of 4 sampled clients (#1, #2 and #3) plus 1 additional client (#6), the facility</p>	W000368	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice? All staff</i></p>	05/23/2014			

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	<p>failed to ensure staff administered medications as ordered by the physician.</p> <p>Findings include:</p> <p>The facility's BDDSR (Bureau of Developmental Disabilities Services Reports) and investigations were reviewed on 4/29/14 at 1:41 PM. The review indicated the following:</p> <p>-BDDSR dated 4/10/14 indicated, "[Client #6] was not given his 9:00 AM dose of 300 MG (Milligrams) of Gabapentin."</p> <p>-BDDSR dated 4/8/14 indicated, "Relief staff, [DSP (Direct Support Professional) #1], notified [TL (Team Leader) #1] that all of [client #1's] 7:00 PM medications were not on the medication strip when he went to pass his medications. [TL #1] instructed [DSP #1] to look in the bottom of the tote (pharmacy delivery tote). [DSP #1] stated that there were no 7:00 PM medications for [client #1] anywhere. [TL #1] instructed [DSP #1] to call the nurse, [LPN (Licensed Practical Nurse) #1]. [TL #1 was informed at 7:00 AM this morning by, [DSP #2], that he had made a medication error yesterday morning. [TL #1] will get statement from [DSP #2] regarding how he believed the error occurred. [DSP #2] stated that he</p>		<p>will attend mandatory training on 5/9/14. Training will review proper medication administration procedures. Training will be completed by the RN for the group home and include a medication administration competency check. Training will also include a review of all medication administration goals and the appropriate times to provide this training. <i>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</i> Training will include medication administration and goals for all residents living in the home. All staff will pass the competency test in order to continue to administer medications. Any staff not showing competency during this evaluation will receive further retraining prior to passing any further medications. All staff will demonstrate proper implementation of goals during the training as well. <i>What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur? How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</i> Nurse Consultant, Team Leader and Manager will continue to provide onsite observations of the medication</p>		

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	<p>had given [client #1] all of his 7:00 PM medications when he gave his 7:00 AM medications. [Client #1's] 7:00 PM medications were Baclofen 20 MG, Baclofen 10 MG, Oxcarazepin 150 MG and Triheyphen 2 MG."</p> <p>-BDDSR dated 1/22/14 indicated, "[DSP #5] did not administer, [client #2's], 9:00 PM medications as ordered."</p> <p>-BDDSR dated 1/20/14 indicated, "[DSP #3] was passing [client #3's] 9:00 PM medications on 1/19/14. The medications are in multi-dose packs which are packaged and labeled by the pharmacy. [DSP #3] gave [client #3] her 9:00 PM medications and he also gave her 2 of her 7:00 AM medications for 1/20/14. [Client #3] was given 100 MG of Dantrolene and 20 MG of Baclofen at 9:00 PM on 1/19/14 instead of 7:00 AM on 1/20/14 as scheduled and labeled on the pharmacy package."</p> <p>-BDDSR dated 8/28/14 indicated, "... [client #1] did not receive his Buspirone Tablet 10 MG at 7:00 AM."</p> <p>-BDDSR dated 8/18/13 indicated, "GH (Group Home) [TL (Team Leader) #1] was informed that [client #2] had not received her Carbonize (sic) 100 MG (Milligrams) (3 tablets) at 8:00 AM on</p>		<p>administration procedures being used. These observations will be completed daily for 1 week after the 5/9/14 training to ensure staff continue to utilize proper procedures. After that week of observations, weekly observations will occur for 4 weeks. Assuming all competency returns to standard, the nurse consultant will resume monthly observations. New Hope of Indiana continues to have systematic response to medication errors. All staff will receive a copy of those procedures in scheduled staff meetings 5/13/14 and 5/14/14. Procedural response to all med errors is nurse retraining and supervisory follow up in respect to disciplinary actions. A coaching then expectation approach is followed. See attached Medication Error Procedures for details. No revision to the existing NHI medication errors procedure is found necessary. New Hope of Indiana Quality Assurance Department and Group Home Director track all medication errors. Oversight is given to trends and concerns. Medication error rate for this home has dropped by 50% over the past year due to increased oversight, training and systematic improvements.</p>	

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NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC				STREET ADDRESS, CITY, STATE, ZIP CODE 9001 N HOLLIDAY DR INDIANAPOLIS, IN 46260			
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	<p>8/17/13. [DSP (Direct Support Professional) #1] went to administer [client #2's] 5:00 PM dose of Carbamazepm (sic) 100 MG. He noticed that a new card had not been started. [DSP #1] doubled checked the previous card and had discovered that [client #2] had not received her 8:00 AM dose."</p> <p>-BDDSR dated 6/26/13 indicated, "[Client #3] was not given her 8:00 PM dose of 5 MG Oxybutynin."</p> <p>1. Client #1's record was reviewed on 4/30/14 at 12:04 PM. Client #1's Physician's Order Form (POF) dated 3/26/14 indicated client #1 should receive the following medications at the 7:00 AM medication administration time:</p> <p>-Baclofen Tablet 10 MG (Milligram): Give one tablet by mouth twice daily (Spasticity) at 7:00 AM and 7:00 PM.</p> <p>-Baclofen Tablet 20 MG: Give one tablet by mouth twice daily at 7:00 AM and 7:00 PM.</p> <p>-Citalopram Tablet 40 MG: Give one tablet by mouth daily (Depression) at 7:00 AM.</p> <p>-DOK (Docusate) Capsule 100 MG: Give one capsule by mouth every morning for</p>						

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	<p>constipation at 7:00 AM.</p> <p>-Ferrous Sulfate Tablet 325 MG: Give one tablet by mouth every morning for anemia at 7:00 AM.</p> <p>-Oxcarazepin Tablet 150 MG: Give one tablet by mouth twice daily (seizures) at 7:00 Am and 7:00 PM.</p> <p>-Trihexyphen Tablet 2 MG: Give one half tablet by mouth twice daily (drooling) at 7:00 AM and 7:00 PM.</p> <p>2. Client #2's record was reviewed on 4/30/14 at 10:44 AM. Client #2's POF dated 3/26/14 indicated client #2 had a prescription dated 10/29/12 for Carbamazepin Chewable 100 MG, give 3 tablets (300 MG), PO (By Mouth) 3 times daily (8:00 AM, 5:00 PM and 9:00 PM) for seizures. Client #2's POF dated 3/26/14 indicated client #2 should receive the following medications at 9:00 PM:</p> <p>-Abilify 2 MG Tablet: Give one tablet by mouth every night at bedtime (depression) at 9:00 PM.</p> <p>-Acetaminophen 650 MG Tablet: Give two tablets by mouth twice daily for arthritic pain at 7:00 AM and 9:00 PM.</p>						

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	<p>-Calcium Citrate 200 MG Tablet: Give one tablet by mouth 3 times daily at 8:00 AM, 5:00 PM and 9:00 PM.</p> <p>-Carbamazepine Chewable 100 MG: Give three tablets by mouth three times daily for seizures at 8:00 AM, 5:00 PM and 9:00 PM.</p> <p>-Glycopyrrol Tablet 1 MG: Give one tablet by mouth two times daily for drooling at 8:00 AM and 9:00 PM.</p> <p>-Hydroxychlor Tablet 200 MG: Give one tablet by mouth twice daily with food (Arthritis) at 7:00 AM and 9:00 PM.</p> <p>-Loratadine Tablet 10 MG: Give one tablet by mouth at bedtime (Allergies) at 9:00 PM.</p> <p>-Sertraline Tablet 100 MG: Give one half table by mouth twice daily with meals (Anti-Depressant) at 9:00 PM.</p> <p>3. Client #3's record was reviewed on 4/30/14 at 11:24 AM. Client #3's POF dated 3/26/14 indicated client #3 should receive the following medications:</p> <p>-Baclofen Tablet 20 MG: Give one tablet by mouth 3 times daily for spasticity at 7:00 AM, 5:00 PM and 9:00 PM.</p>						

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	<p>-Dantrolene Capsule 100 MG: Give one capsule by mouth every morning for spasticity at 7:00 AM.</p> <p>-Fluticasone Spray 50 MCG (Micro Grams): give one spray in each nostril twice daily for decongestant at 7:00 AM and 8:00 PM.</p> <p>-V-C Forte Capsule: Give one capsule by mouth daily for supplement at 7:00 AM.</p> <p>4. Client #6's record was reviewed on 5/1/14 at 5:36 PM. Client #6's POF dated 3/26/14 indicated client #6 had a prescription order dated 10/29/12 for Gabapentine Capsule 300 MG, Give one capsule by mouth twice daily for seizures, at 9:00 AM and 5:00 PM.</p> <p>QIDP #1 (Qualified Intellectual Disabilities Professional) was interviewed on 4/30/14 at 12:30 PM. QIDP #1 indicated medications should be administered as ordered by the physician.</p> <p>LPN (Licensed Practical Nurse) #1 was interviewed on 4/30/14 at 2:20 PM. LPN #1 indicated facility staff should administer medications as ordered by the physician.</p> <p>9-3-6(a)</p>			

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W000382	<p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation, record review and interview for 1 additional client (#6), the facility failed to ensure client #6's prescription mouthwash was secured/locked.</p> <p>Findings include:</p> <p>Observations were conducted at the facility on 4/30/14 from 6:00 AM through 8:15 AM. At 6:40 AM, DSP (Direct Support Professional) #1 placed 15 ML (Milliliters) of Chlorhex Solution into a plastic cup. DSP #1 then placed the Chlorhex Solution in the group home's bathroom next to clients #4 and #6's bedrooms. DSP #1 then left the Chlorhex Solution in the bathroom and continued passing the morning medications. The Chlorhex Solution remained in the bathroom unattended until 8:00 AM.</p> <p>Client #6's record was reviewed on 5/1/14 at 5:36 PM. Client #6's Physician's Order Form (POF) dated 3/26/14 indicated client #6 had a prescription order for Chlorhex Solution .12%: (Gum Health) Apply 15 ML in mouth around tongue and gums twice daily.</p>	W000382	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice? All staff will attend mandatory training on 5/9/14. Training will review proper medication administration procedures. Training will be completed by the RN for the group home and include a medication administration competency check. Training will also include securing medications and a review of all medication administration goals and the appropriate times to provide this training. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Training will include medication administration and goals for all residents living in the home. All staff will pass the competency test in order to continue to administer medications. Any staff not showing competency during this evaluation will receive further retraining prior to passing any further medications. All staff will demonstrate proper implementation of goals during the training as well. What measures will be put into place or what systematic changes you will make to ensure that the deficient</i></p>	05/23/2014

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	<p>DSP #1 was interviewed on 4/30/14 at 7:15 AM. DSP #1 indicated he placed client #6's Chlorhex Solution on the bathroom sink for client #6 to use when he showered. DSP #1 indicated client #6's Chlorhex Solution was a prescription medication.</p> <p>LPN (Licensed Practical Nurse) #1 was interviewed on 4/30/14 at 2:20 PM. LPN #1 indicated client #6's Chlorhex Solution was a prescription medication and should not be left unattended in the bathroom.</p> <p>9-3-6(a)</p>		<p><i>practice does not recur? How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</i> Nurse Consultant, Team Leader and Manager will continue to provide onsite observations of the medication administration procedures being used. These observations will be completed daily for 1 week after the 5/9/14 training to ensure staff continue to utilize proper procedures. After that week of observations, weekly observations will occur for 4 weeks. Assuming all competency returns to standard, the nurse consultant will resume monthly observations. New Hope of Indiana continues to have systematic response to medication errors. All staff will receive a copy of those procedures in scheduled staff meetings 5/13/14 and 5/14/14. Procedural response to all med errors is nurse retraining and supervisory follow up in respect to disciplinary actions. A coaching then expectation approach is followed. See attached Medication Error Procedures for details. No revision to the existing NHI medication errors procedure is found necessary. New Hope of Indiana Quality Assurance Department and Group Home Director track all medication errors. Oversight is given to trends and concerns.</p>		

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			Medication error rate for this home has dropped by 50% over the past year due to increased oversight, training and systematic improvements.	