STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G716	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/01/2014
NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 8521 CROWN POINT RD INDIANAPOLIS, IN 46278	

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W000000	This visit was for a fundamental recertification and state licensure survey. Dates of Survey: 7/28, 7/29, 7/30, 7/31, and 8/1/2014. Provider Number: 15G716 Facility Number: 004061 AIM Number: 200483530 Surveyor: Susan Eakright, QIDP These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review completed August 8, 2014 by Dotty Walton, QIDP.	W000000		
W000130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. Based on observation, record review, and interview, for 1 of 2 sampled client (client #2) and 1 additional client (client #4), the facility failed to encourage and teach personal privacy when opportunities existed. This observation was a breach in	W000130	*What corrective actions will be accomplished for these residents found to have been affected by this practice? How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.*	08/29/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Findings include: On 7/30/14 from 5:20am until 7:25am, observation and interview were completed with GHS (Group Home Staff) #7, clients #2 and #4. From 5:20am until 5:40am, GHS #7, and clients #2 and #4 were in the single bathroom together. At 5:35am, the surveyor went to the bathroom door after GHS #7 had exited the bathroom and walked to the back of the group home to client #1's bedroom door. At 5:35am, inside the bathroom client #2 was observed to sit near/over the toilet area nude from the waist down. At 5:35am, client #4 was observed in the shower with the drape partially closed and client #4 was nude. At 5:40am, GHS #7 exited the bathroom with client #4. Client #4 was dressed, had wet hair, and was seated in her wheelchair. At 5:35am, GHS #7 stated "Yes, [clients #2 and #4] were showering with" one staff, GHS #7. GHS #7 stated he showered the two clients together inside the bathroom because "there was only one staff" to complete the morning routine. No privacy was taught or encouraged when opportunities exited. On 7/30/14 at 10:55am, client #2's 3/12/14 ISP (Individual Support Plan) and record review was conducted and		the daily operation of the home. This staff received coaching action due to his failure to follow existing transfer and lift procedures and privacy conduct for the agency as well as failure to follow individual specific risk plans for transfers. All staff were retrained on privacy measures, daily schedule to organize bathroom times and all transfer/lift risk plans. *What measures will be put into place or what systematic changes the facility will make to ensure the deficient practice does not recur. How the corrective actions will be monitored.* Team Leader, Nurse Consultant or Manager will conduct daily observations for 3 weeks to ensure that the proper privacy and procedures are being utilized. After 3 weeks, the QIDP or Team Leader will continue informal observations when onsite weekly.	

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	indicated client #2 was non verbal. Client #2's 3/12/14 ISP indicated she could not advocate for herself to request privacy. On 7/31/14 at 8:55am, an interview with the Group Home Manager/Qualified Intellectual Disabilities Professional (GHM/QIDP) was conducted. The GHM/QIDP indicated clients #2 and #4 should not have been bathed at the same time. The GHM/QIDP indicated staff should teach and encourage during formal and informal opportunities personal privacy during dressing and/or the clients' morning routines. 9-3-2(a)			
W000149	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 observation, record review, and interview, for 1 of 2 allegations of neglect (for client #2), the facility neglected to implement their Abuse/Neglect/Mistreatment policy to ensure staff were awake to provide staff supervision for client #2. Findings include:	W000149	*What corrective actions will be accomplished for these residents found to have been affected by this practice? How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.* New Hope of Indiana maintains a compliant policy and procedure to mitigate and respond to	08/29/2014

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	On 7/28/14 at 1:36pm, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed from 07/01/2013 through 07/28/2014 and indicated the following: -A 8/20/13 BDDS report for an incident on 8/20/13 at 1:00pm, indicated "At approximately 12:50pm, the workshop supervisor "entered the Day Services craft room and found the staff person assigned to care for [client #2] sleeping. Staff had to be roused to wake. [Staff person] was told to clock out and go home...Based on interview with another staff member of day services leadership, it was also determined that the staff had not assisted [client #2] in the restroom for over three hours." The report indicated the staff person involved was terminated after the incident. On 7/29/14 from 2:55pm until 5:25pm, and on 7/30/14 from 5:20am until 7:25am, observation and interview was completed with GHS #1, GHS #2, GHS #3, GHS #4, GHS #5, GHS #7 and client #2. Client #2 wore an incontinent brief during both observation periods and sat in her wheelchair. On 7/29/14 from 2:55pm until 5:25pm, client #2 was assisted by GHS #4, the House Manager (HM), and GHS #5 assisted client #2 to		allegations of abuse, neglect. This incident was addressed immediately upon discovery and investigated swiftly and thoroughly. Staff was terminated at conclusion. All staff were retrained on the expectations of daily operations and ramifications to breach of those. *What measures will be put into place or what systematic changes the facility will make to ensure the deficient practice does not recur. How the corrective actions will be monitored.* New Hope of Indiana will continue to follow current policy and procedure for abuse, neglect. All allegations will continue to be investigated. Prevention of abuse, neglect will include screening at hire, initial and ongoing training regarding abuse, neglect, conduct and responsibilities and how to report concerns.	

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	her bedroom, used a Hoyer lift to transfer client #2 to the bed, and changed her incontinent brief. During both observation periods client #2 had incontinent briefs in her bedroom. On 7/30/14 at 10:55am, client #2's 3/12/14 ISP (Individual Support Plan) and record review was conducted. Client #2's 2/14/14 ISP indicated a specific goal/objective for client #1 to "pull the sanitizing wipe from the container" for her toileting needs. Client #2's record indicated she was non verbal, required a Hoyer lift for transfers, used a wheel chair for mobility, did not verbally interact with staff to make requests, and needed a guardian. On 7/31/14 at 8:55am, an interview with the Group Home Manager/Qualified Intellectual Disabilities Professional (GHM/QIDP) was conducted. The GHM/QIDP indicated client #2 was incontinent of bowel and bladder, wore adult briefs, was non verbal, had a guardian, and did not verbally make requests of staff for her wants/needs. The GHM/QIDP indicated when staff were sleeping on duty and not supervising client #2 it was neglect. The GHM/QIDP indicated the facility followed the policy/procedure for BDDS reporting.			

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	On 7/28/14 at 2:45pm, a record review was conducted of the 6/11/2002 BDDS "Incident Reporting" policy and procedure indicated "...Neglect, includes failure to provide appropriate care, food, medical care, or supervision...." On 7/28/14 at 2:40pm, a review of the facility's records indicated the facility's 1/2014 "Suspected Abuse" policy which 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 (sic) appropriate care and the basic necessities of life such as denial of sleep, food, drink, shelter, clothing, and medical care or treatment...." 9-3-2(a)			
W000192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. Based on observation, record review, and interview, for 1 of 2 sampled clients (client #2), the facility failed to ensure staff displayed knowledge and competence	W000192	*What corrective actions will be accomplished for these residents found to have been affected by this practice? How the facility will identify other residents having the potential to be affected by the same deficient practice and what*	08/29/2014

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	related to client #2's seat belt use, Hoyer lift with sling for transfers, and medication administration. Findings include: 1. On 7/30/14 from 5:20am until 7:25am, observation and interview was completed with GHS (Group Home Staff) #7 and client #2. The Hoyer lift, with a sling on top of it, sat in the hallway unused. From 5:20am until 5:40am, GHS #7 and clients #2 and #4 were in the single bathroom together. At 5:35am, the surveyor went to the bathroom door after GHS #7 had exited the bathroom and walked to the back of the group home to client #1's bedroom door. At 5:35am, inside the bathroom, client #2 was observed to sit near/over the toilet area nude from the waist down on a shower chair without a seat belt to secure her to the shower chair. At 5:35am, GHS #7 stated "Yes, [clients #2 and #4] were showering with" one staff, GHS #7. GHS #7 stated he showered the two clients together inside the bathroom because "there was only one staff" to complete the morning routine. At 5:47am, GHS #7 exited the bathroom with client #2 in a shower chair without a seat belt, dressed in street clothing with wet hair, and rolled the shower chair with client #2 unsecured into her bedroom.		*corrective action will be taken.* This staff's techniques and procedures were not consistent with how he has been trained. He and all other staff have been retrained on all transfer/lift procedures for all individuals in the home as well as proper safety procedures when utilizing equipment. Staff also received a verbal coaching to address his failure to follow established protocols. Staff were also retrained on medication administration specific to Milk of Magnesia measurement and the requirement to never administer a medication that has been prepared by someone else. *What measures will be put into place or what systematic changes the facility will make to ensure the deficient practice does not recur. How the corrective actions will be monitored.* Nurse Consultant, Team Leader or Manager will monitor transfer and lift procedures as well as medication administration daily for 3 weeks to ensure that procedures and plans are being implemented successfully. After that period, the Team Leader, Nurse Consultant or Manager/QIDP will continue to informally monitor continuance weekly, documentation of observations will discontinue.	

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	From 5:47am until 6:15am, client #2 sat alone inside her bedroom dressed on the shower chair without a seat belt. At 6:15am, GHS #7 entered client #2's bedroom and closed the door. At 6:20am, GHS #7 opened client #2's bedroom door, exited the bedroom, and client #2 was in bed. At 6:20am, GHS #7 stated he did not need the Hoyer lift to transfer client #2 to/from her bed to the shower chair or to/from the shower chair to bed because he "was strong enough" to complete client #2's transfer then bent his arm to form a muscle in his arm. On 7/30/14 at 10:55am, client #2's 3/12/14 ISP (Individual Support Plan) and record review was conducted. Client #2's record indicated client #2 was non verbal, used a wheelchair, shower chair with a seatbelt use, Hoyer lift with sling, and hospital bed because she was dependent on staff for transfers, basic needs, and safety. Client #2's 3/12/14 ISP indicated she could not advocate for herself. Client #2's ISP and record indicated a Hoyer lift with sling should "be used at all times" for transfers to prevent unknown injuries to client #2. Client #2's 2/13/13 Physical Therapy assessment documented client #2's need for a Hoyer lift and sling during "all" transfers, a shower chair, a hospital bed with side rails, and a molded wheelchair.			

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	On 7/31/14 at 8:55am, an interview with the Group Home Manager/Qualified Intellectual Disabilities Professional (GHM/QIDP) and the Agency's Registered Nurse was conducted. The GHM/QIDP indicated client #2 should have a seat belt on when in the shower chair and/or when in her molded wheel chair. The GHM/QIDP stated client #2 should be transferred with "a Hoyer lift and sling for all transfers" for the protection to prevent unknown injuries to client #2 and prevent injuries to staff. The GHM/QIDP and the Agency Registered Nurse (RN) both stated the staff were taught upon hire and retrained as needed that client #2 was to be "only transferred" with the use of a Hoyer lift with a sling and client #2 was to wear a seat belt when up in a shower chair and/or wheel chair. The RN indicated the staff failed to display competency and knowledge for client #2's seat belt use and Hoyer lift with sling use. 2. On 7/30/14 at 6:30am, GHS #7 came to the medication area to notify GHS #4 that he had not administered client #2's Milk of Magnesia medication for constipation at 6:00am. At 6:30am, GHS #4 poured 15ml (milliliters), dispensed into a graduated cup (a plastic medication cup with measurement), then GHS #4			

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	poured the Milk of Magnesia into a 5oz (ounce) Dixie cup and added water to the Dixie cup. GHS #4 called to GHS #7 to come and get the medication mixture. At 6:36am, GHS #7 came to the medication area, retrieved the Dixie cup medication mixture from GHS #4, went to client #2 inside her bedroom, and administered the Dixie cup medication to client #2 by her gastro tube/G-tube. At 6:36am, GHS #7 indicated he did not assemble client #2's medication in which he was administering. GHS #7 indicated he did not "for sure" know the amount of Milk of Magnesia medication inside the Dixie cup mixture. At 7:25am, Client #2's 7/2014 MAR (Medication Administration Record) indicated "Milk of Magn (Magnesia) 1200/15, give 15ml 1 tablespoonful via G-tube every morning for constipation. (At) 6:00am." Client #2's 7/30/2014 MAR (for the 7/30/14 at 7:25am) Milk of Magnesia medication indicated GHS #4 signed as administered. On 7/30/14 at 10:55am, client #2's record was reviewed. Client #2's 6/26/14 "Physician's Order" indicated "Milk of Magn (Magnesia) 1200/15, give 15ml 1 tablespoonful via G-tube every morning for constipation." On 7/31/14 at 8:55am, an interview with the Group Home Manager/Qualified			

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	Intellectual Disabilities Professional (GHM/QIDP) and the Agency's Registered Nurse was conducted. The GHM/QIDP and the RN both indicated the staff were trained to follow the Core A/Core B Living in the Community training to administer medications in the group home. The RN indicated the same staff who prepared the medication should be the only staff to administer the medication. The RN indicated the staff failed to demonstrate competency after being trained to administer medication for client #2. On 7/31/14 at 9:15am, a review of the facility's 12/2014 "Medication Administration" policy indicated the staff will complete the Core A and Core B Medication Administration Curriculum which includes, but is not limited to, the following information: "All staff adhere to the six rights of medication administration..." On 7/31/14 at 9:15am, a review of the 2004 "Living in the Community" medication administration training manual, Core Lesson 2: Responsibilities in the Area of Medication Administration indicated the same staff who prepares the medication should be the same staff who administers the medication and signs the clients' medication record to indicate			

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	administration was prepared, observed, and completed. On 7/30/14 at 9:15am, the facility's personnel records were reviewed. GHS #4 was hired on 5/14/12 and completed medication administration training for Core A/Core B on 5/22/12. GHS #7 was hired on 6/18/12 and completed medication administration training for Core A/Core B on 6/21/12. 9-3-3(a)			
W000227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review, and interview, for 1 of 1 sampled client (client #2) who was non verbal and for 2 of 2 sampled clients (clients #1 and #2) who lacked toileting skills, the facility failed to develop a training program for client #2's communication needs and failed to develop a training program to meet clients #1 and #2's toileting needs. Findings include:	W000227	*What corrective actions will be accomplished for these residents found to have been affected by this practice?* QIDP has completed a reassessment of toileting needs for Clients #1 and #2. He has also defined the specific care and program needs in Client #1 and #2 ISP. In addition, a communication goal for Client #2 had recently been pulled for revision. It has been implemented. *How the facility will identify other residents having the potential to be*	08/29/2014

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	1. On 7/29/14 from 2:55pm until 5:25pm, and on 7/30/14 from 5:20am until 7:25am, observation and interview was completed with GHS #1, GHS #2, GHS #3, GHS #4, GHS #5, GHS #7 and client #2. Clients #1 and #2 wore incontinent briefs during both observation periods. On 7/29/14 from 2:55pm until 5:25pm, client #1 independently wheeled her wheelchair into the bathroom, requested staff assistance, and the staff followed client #1 into the bathroom to assist her. On 7/29/14 at 4pm, the House Manager indicated client #1 was incontinent of bowel and bladder and needed staff assistance to use the toilet inside the bathroom. The House Manager stated client #1 could take herself at times to the bathroom and "always" needed staff to assist her. On 7/29/14 from 2:55pm until 5:25pm, client #2 was assisted by GHS #4, the House Manager (HM), and GHS #5 assisted client #2 to her bedroom, used a Hoyer lift to transfer client #2 to the bed, and changed her incontinent brief. During both observation periods client #2 had incontinent briefs in her bedroom. On 7/30/14 from 5:20am until 7:25am, client #1 was encouraged to use the bathroom by GHS #7. At 6:15am, GHS #7 encouraged and assisted client #1 to use the bathroom.		*affected by the same deficient practice and what corrective action will be taken.* All staff were retrained for communication and toileting programs and plans for each individual in home. All individuals have toileting assessments and plans on their ISPs. *What measures will be put into place or what systematic changes the facility will make to ensure the deficient practice does not recur.* *How the corrective actions will be monitored.* Team Leader will conduct observations 3 times weekly for 3 weeks. After the 3 week period, observations and team coaching will continue during regular routine visits. QIDP and Nurse Consultant will monitor the incontinence and care needs progress as well as program implementation during their weekly routine visits as well as the monthly progress summary that is charted.	

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	On 7/30/14 at 9:15am, client #1's 2/14/14 ISP (Individual Support Plan) and record review was conducted and did not indicate client #1 was incontinent of bowl and/or bladder. Client #1's 2/14/14 ISP indicated a goal/objective for client #1 "to get toilet paper" for her toileting needs. Client #1's 2/14/14 ISP and 2013 CFA (Comprehensive Functional Assessment) did not indicate client #1 was incontinent of bowel and/or bladder and did not include how/when staff were to assist client #1 during her toileting opportunities. On 7/30/14 at 10:55am, client #2's 3/12/14 ISP (Individual Support Plan) and record review was conducted, did not indicate client #2 was incontinent of bowl and/or bladder, and did not include that client #2 wore adult briefs. Client #2's 3/12/14 ISP indicated a specific goal/objective for client #1 to "pull the sanitizing wipe from the container" for her toileting needs. Client #2's 3/12/14 ISP and 2013 CFA (Comprehensive Functional Assessment) did not indicate client #2 was incontinent of bowel and/or bladder and did not include how/when staff to assist client #2 during her toileting opportunities. 2. On 7/29/14 from 2:55pm until 5:25pm, and on 7/30/14 from 5:20am			

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	until 7:25am, observation and interview was completed with GHS #1, GHS #2, GHS #3, GHS #4, GHS #5, GHS #7 and client #2. Client #2 was non verbal, sat in a wheelchair, shook a bell at times, used eye gaze to make eye contact, and was dependent on staff to anticipate her wants/needs. During both observation periods staff did not encourage client #2 to communicate back to the staff her wants and needs. During both observation periods facility staff turned on and off the television set in client #2's bedroom and living room without offering client #2 the opportunity to turn it on. On 7/30/14 at 10:55am, client #2's 3/12/14 ISP (Individual Support Plan) and record review was conducted, indicated client #2 was non verbal and included a communication goal to turn on the television with staff hand over hand assistance and "to choose a picture of TV remote verses a picture of a horse via eye gaze (sic)." Client #2's 3/12/14 ISP did not indicate a specific goal/objective for client #2 to express her wants/needs or how staff were to determine how client #2 communicated her wants and needs. Client #2's 3/12/14 ISP and 2013 CFA (Comprehensive Functional Assessment) indicated client #2 was non verbal and did not include how staff were to assist			

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	client #2 to determine her communication of her wants and needs. On 7/31/14 at 8:55am, an interview with the Group Home Manager/Qualified Intellectual Disabilities Professional (GHM/QIDP) was conducted. The GHM/QIDP indicated clients #1 and #2 wore adult briefs because clients #1 and #2 were incontinent of bowel and bladder. The GHM/QIDP indicated clients #1 and #2's plans did not include a training objective to teach clients #1 and #2 to use the toilet or address their toileting needs. The GHM/QIDP indicated client #2's plans did not include a communication goal for client #2 to express her wants and needs. The GHM/QIDP indicated client #2's plans did not include how facility staff were to determine her communication of client #2's wants and needs. 9-3-4(a)			
W000391	483.460(m)(2)(ii) DRUG LABELING The facility must remove from use drug containers with worn, illegible, or missing labels. Based on observation, record review, and interview, for 1 of 2 sampled clients (client #1), the facility failed to ensure client #1's insulin medication for her	W000391	*What corrective actions will be accomplished for these residents found to have been affected by this practice?* The labels for all drugs and treatments were	08/29/2014

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	supper insulin dosage was included on the medication container from the pharmacy on 7/29/14. Findings include: On 7/29/14 at 4:45pm, GHS (Group Home Staff) #6 selected client #1's insulin bottle from the locked medication box. GHS #6 compared the medication to client #1's 7/2014 MAR (Medication Administration Record), drew 6 units of Novolog Insulin 100/ml (milliliters) into a syringe, and administered the medication to client #1. At 4:45pm, client #1's Novolog Insulin pharmacy bottle indicated "Novolog Inj (Injection) 100/ml, inject 6 units at breakfast and lunch." No supper meal was indicated on the Novolog Insulin bottle. On 7/30/14 at 9:15am, client #1's 7/2014 MAR was reviewed which indicated "Novolog Inj. (Inject Insulin) 100/ml, inject 6 units sub-Q (subcutaneously) daily with dinner (for Diabetes Mellitus)." On 7/30/14 at 9:15am, client #1's record was reviewed. Client #1's 6/26/14 "Physician's Order" indicated "Novolog (Insulin) 100/ml, inject 6 units sub-Q (subcutaneously) daily with dinner (for Diabetes Mellitus)."		reviewed by the nurse consultant during the week following the exit conference. All labels are legible, illegible label was replaced 8/2/14. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.* Staff were retrained on drug labeling, how to ensure label is readable and what to do if the label becomes illegible. *What measures will be put into place or what systematic changes the facility will make to ensure the deficient practice does not recur. How the corrective actions will be monitored.* Nurse Consultant will review drug labels weekly during her routine site visits.	

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	On 7/31/2014 at 8:55am, an interview with the agency's Registered Nurse (RN) was conducted. The RN stated "all" medications administered by the group home staff to clients living in the group home should have a "legible pharmacy label" which is to include specifics for client #1's insulin. The RN stated "if a client's medication bottle was missing the direction information from the pharmacy label, then the staff should contact the nurse for guidance before administering the medication." The RN indicated she had not been contacted for clients #1's medication. The RN indicated either the facility staff administered the medication without Supper (or dinner) on the pharmacy label or there possibly could have been a different bottle with the same dosage of Novolog in the box. The RN indicated the facility followed the Core A/Core B training for medication administration and the facility policy and procedure for medication administration. On 7/31/14 at 9:15am, a review of the facility's 12/2014 "Medication Administration" policy indicated the staff will complete the Core A and Core B Medication Administration Curriculum which includes but is not limited to the following information: "All staff adhere to the six rights of medication			

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	administration..." On 7/31/14 at 9:15am, a review of the 2004 "Living in the Community" medication administration training manual, Core Lesson 2: Responsibilities in the Area of Medication Administration indicated medications should be labeled. 9-3-6(a)			
W000436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review, and interview, for 1 of 2 sampled clients (client #1) with adaptive equipment, the facility failed to teach and encourage client #1 to wear her prescribed eyeglasses when opportunities existed. Findings include: On 7/29/14 from 2:55pm until 5:25pm, and on 7/30/14 from 5:20am until 7:25am, observation and interview were completed with GHS #1, GHS #2, GHS #3, GHS #4, GHS #5, GHS #7 and client	W000436	*What corrective actions will be accomplished for these residents found to have been affected by this practice?* Client #1 was assessed during day and evening observation. She wears her glasses all day, but once home, likes to take them off. Staff were retrained on the appropriate reminders and how to encourage her to put them back on. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.* Staff were retrained on all adaptive equipment needs for residents of facility. No other	08/29/2014

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	#2. On 7/29/14 from 2:55pm until 5:25pm, client #1 was not taught, encouraged, or wore her prescribed eyeglasses. During the observation period client #1 cut foods for meal preparation, watched television, completed medication administration, stirred a pitcher of koolaid, and completed dining without her prescribed eyeglasses. On 7/30/14 at 9:15am, client #1's 2/14/14 ISP (Individual Support Plan) record review was conducted and did not indicate a goal/objective for client #1 to wear her prescribed eyeglasses. Client #1's 2/14/14 ISP indicated "glasses, wear during waking hours." Client #1's 11/4/13 vision evaluation indicated she wore prescribed eyeglasses. On 7/31/14 at 8:55am, an interview with the GHM/QIDP (Group Home Manager/Qualified Intellectual Disabilities Professional) was conducted. The GHM/QIDP indicated client #1 wore prescribed eyeglasses to see. The GHM/QIDP indicated client #1 should have been taught and encouraged by the facility staff to wear her prescribed eyeglasses during formal and informal opportunities. 9-3-7(a)		resident wears glasses at this time. All other adaptive equipment needs are in place without client variance from schedule. *What measures will be put into place or what systematic changes the facility will make to ensure the deficient practice does not recur. How the corrective actions will be monitored.* QIDP will conduct observation of Client #1 resistence or compliance with glasses and staff's approach to encouraging her during routine weekly visits to home.	

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W000449	483.470(i)(2)(iv) EVACUATION DRILLS The facility must investigate all problems with evacuation drills and take corrective action. Based on record review and interview for 4 of 4 clients (clients #1, #2, #3, and #4) who lived in the group home, the facility failed to initiate and document effective corrective action to prevent further incidents of lengthy evacuation drill times on the day, evening, and night shifts. Findings include: On 7/28/14 at 2:45pm, record reviews were completed of the facility's evacuation drills for the period from 7/2013 through 7/28/14 which included the participation of clients #1, #2, #3, and #4. The drills did not indicate a reason for each lengthy duration of the drill and did not include corrective measures to ensure prompt evacuation. The drills indicated the following: For day shift: On 7/19/13 at 11:00am, duration 10 minutes, on 10/17/13 at 8:00am duration 10 minutes, on 1/14/14 at 7:30am duration 6 minutes, on 2/19/14 at 2:15pm duration 10 minutes, and on 4/13/14 at	W000449	*What corrective actions will be accomplished for these residents found to have been affected by this practice?How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.*The evacuation plan for home was reviewed. QIDP met directly with staff at retraining to run a mock drill to observe evacuation plan. It was redesigned and simulated to evacuate in less than 5 minutes. All staff were retrained on the evacuation plan and drill actions. *What measures will be put into place or what systematic changes the facility will make to ensure the deficient practice does not recur. How the corrective actions will be monitored.* Manager/QIDP and Team Leader will review drills every month to ensure that evacuation times are acceptable. Evacuation times exceeding 5 minutes will require a reassessment of evacuation plan and drill procedures.	08/29/2014

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	12:10pm duration 10 minutes. For evening shift: On 8/25/13 at 7:20pm duration 17 minutes, on 11/18/13 at 9:45pm duration 6 minutes, on 3/2/14 at 2:00pm duration 10 minutes, on 3/20/14 at 3:30pm duration 10 minutes, and on 5/17/14 at 5:00pm duration 9 minutes. For night shift: On 9/17/13 at 3:45am duration 5 minutes, on 12/14/13 at 6:00am duration 8 minutes, on 1/14/14 at 7:30am duration 6 minutes, on 3/8/14 at 2:30am duration 10 minutes, and on 6/16/14 at 12:00am duration 10 minutes. On 7/31/14 at 8:55am, an interview with the Group Home Manager/Qualified Intellectual Disabilities Professional (GHM/QIDP) was conducted. The GHM/QIDP indicated there were no further documented drills for review. The GHM/QIDP indicated the evacuation drills had lengthy evacuation times because the clients were dependent on staff to complete each drill. The GHM/QIDP stated client #1 and #3 "required" verbal prompts and directions to exit. The GHM/QIDP stated client #2 "required" a Hoyer lift transfer into a wheelchair, and staff physical assistance to exit. The GHM/QIDP stated client #4			

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	"required" staff to transfer her from her bed or chair into her wheelchair and physical assistance by staff to exit. The GHM/QIDP stated "No, none of the drills" included documentation for the reasons why each drill was lengthy in duration and did not include corrective measures to ensure prompt evacuation for clients #1, #2, #3, and #4. 9-3-7(a)			