

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G158	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2011
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NAME OF PROVIDER OR SUPPLIER HOPEWELL CENTER INC	STREET ADDRESS, CITY, STATE, ZIP CODE 915 BITTERSWEET LN ANDERSON, IN46015
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W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of survey: October 31 and November 1 and 2, 2011</p> <p>Surveyor: Kathy Craig, Medical Surveyor III</p> <p>Facility Number: 000694 Provider Number: 15G158 AIMS Number: 100234500</p> <p>These deficiencies also reflect state findings under 460 IAC 9. Quality Review completed 11/18/11 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		
W0249	<p>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, the facility failed for 3 of 4</p>	W0249	To assure compliance with W249 for clients # 1,3, and 4, staff # 1 has been re-trained on	12/02/2011

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>sampled clients (clients #1, #3, and #4) by not implementing their med (medication) goals when the opportunity arose, either formal or informal.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 11/1/11 from 7:00 AM to 8:00 AM, in which a med pass was also observed. Staff #1 administered client #4's nine meds at 7:05 AM. There was no med training with client #4. At 7:19 AM, staff #1 administered client #1's five meds. There was no med training with client #1. At 7:24 AM, staff #1 administered client #3's four meds. There was no med training with client #3.</p> <p>Review on 11/1/11 at 9:55 AM of client #1's records was conducted. His ISP (Individual Support Plan) dated 7/26/11 included his med goal to state the name of his Risperdal (his morning meds included Risperdal).</p> <p>Review on 11/1/11 at 10:25 AM of client #3's records was conducted. His ISP dated 3/17/11 included his med goal to state the time he takes his Vitamin E (7:00 AM).</p> <p>Review on 11/1/11 at 10:40 AM of client #4's records was conducted. His ISP</p>		<p>medication administration procedures with emphasis on the criticalness of implementing medication training programs on a formal or informal basis at each administration. Person Responsible: Facility Nurse and QMRPT to assure ongoing compliance with W249 for all clients, facility nurse and QMRP to increase direct observation and supervision of medication administration. In addition to assuring all Core A and B procedures are followed, observations will also include assuring medication training programs are being completed on a formal or informal basis at each medication administration. LPN and QMRP will now each complete at least 1 medication administration observation each month. Observations are to be documented on either the Nurse House Visit Checklist or the QMRP Active Treatment Review Sheets. Completed observations will be returned to Community Services Director for monitoring of compliance. (Revised checklists attached as A and B) Person Responsible: Community Services Director</p>		

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W0262	<p>dated 7/22/11 included his med goal to repeat the purpose of his Simvastatin - which is given at 8:00 PM.</p> <p>Interview on 11/1/11 at 11:40 AM with the QMRP (Qualified Mental Retardation Professional) was conducted. She indicated staff should be running the med goals formally and informally.</p> <p>9-3-4(a)</p> <p>The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.</p> <p>Based on record review and interview, the facility failed for 2 of 4 sampled clients (clients #1 and #2) by not ensuring the Human Rights Committee (HRC) reviewed and approved their behavior plans before implementation.</p> <p>Findings include:</p> <p>Review on 11/1/11 at 9:55 AM of client #1's records was conducted. Client #1's Behavioral Guidelines dated 7/19/11 indicated his target behaviors included verbal abuse, physical abuse, and destruction of property. It indicated client</p>	W0262	<p>To ensure compliance with W262, HRC approval has been obtained for behavior plans for clients # 1 and 2. (Attachments C and D) Person Responsible: Facility nurse To assure ongoing compliance with W262 for all residents, facility form titled ' New Admission Checklist ' has been revised to now include HRC approval for any psychotropic medications. QMRP responsible to assure facility nurse has obtained HRC approval within required timeframes. (Revised checklist attached as attachment E) Person Responsible: QMRP</p>	12/02/2011	

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	<p>#1 was on 1.5 mg (milligrams) Risperdal for behavior mood disorder and 30 mg. of D-Amphetamine ER (Extended Release) for Attention Deficit Hyperactivity Disorder. There was no documentation the HRC reviewed or approved client #1's behavior plan.</p> <p>Review on 11/1/11 at 10:10 AM of client #2's records was conducted. Client #2's Behavioral Guidelines dated 7/18/11 indicated his target behaviors included agitation and delusions. It indicated he was on 1000 mg. of Depakote ER for psychotic disorder and 6 mg. of Invega also for psychotic disorder. There was no documentation the HRC reviewed and approved this plan.</p> <p>Interview on 11/1/11 at 11:00 AM with the QMRP (Qualified Mental Retardation Professional) was conducted. She indicated the HRC had not reviewed or approved client #1 and #2's behavior plans.</p> <p>9-3-4(a)</p>				

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W0371	<p>The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise.</p> <p>Based on observation, record review and interview, the facility failed for 1 of 4 sampled clients (client #2) by not including a med (medication) goal in his ISP (Individual Support Plan).</p> <p>Findings include:</p> <p>On 11/1/11 from 7:00 AM to 7:55 AM, observations were conducted at the group home. At 7:23 AM, client #2 was given one 25 mg (milligram) Atenolol tablet (for hypertension) and one 10 mg. Lisinopril tablet (for hypertension).</p> <p>Review on 11/1/11 at 10:10 AM of client #2's records was conducted. Client #2's ISP dated 7/6/11 did not include a med goal. Client #2's Annual Functional Assessment dated 6/13/11 indicated he knows the names of meds, purpose of meds, and times he takes his meds. Client #2's MAR (Medication Administration Record) dated November, 2011, included the above two medications.</p> <p>Interview on 11/1/11 at 11:10 AM with the QMRP (Qualified Mental Retardation Professional) stated client #2 did not have</p>	W0371	<p>For Client # 2, QMRP had actually written a formal medication training program at the time of his annual (7/11) but due to oversight program had never been implemented. Client #2 now has medication training program in place and implemented. (Attachment F)Person Responsible: QMRPTo assure ongoing compliance with W 371 for all clients, procedures have been revised to reflect QMRP will now give house manager copy of the IDT Case Conference Agreement form which summarizes all training goals to be implemented. House manager will assure that that all written training programs have been received from QMRP and are implemented within 1 week of IDT meeting. Person Responsible: QMRP</p>	12/01/2011			

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W9999	<p>a med goal and "there was no reason he shouldn't have one."</p> <p>9-3-6(a)</p> <p>State Findings:</p> <p>This Community Residential Facilities for Persons with Developmental Disabilities Rule was not met: 460 IAC 9-3-3 Facility Staffing (e) Prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin test or chest X-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered.</p> <p>Based on record review and interview, the facility failed for 1 of 3 staff persons reviewed (staff #1) by not ensuring staff #1's tuberculosis (TB) test by chest x-ray had been done annually or at least an annual checklist of negative or positive symptoms.</p> <p>Findings include:</p>	W9999	<p>To assure compliance with W9999, facility nurse has now completed the TB Follow Up Questionnaire for staff # 1. Questionnaire showed negative symptoms of TB. (Attachment G)Person Responsible: Facility Nurse To assure ongoing compliance with W9999 for all staff, facility has revised procedures to reflect that any staff who have a positive mantoux skin test will be required to have a chest x-ray. If chest xray reveals no positive read for TB, on at least an annual basis, the facility nurse will administer the TB Follow Up Questionnaire. If upon completion of questionnaire there are any positive symptoms for TB, staff will be immediately required to have chest xray. If follow up questionnaire reveals negative for symptoms of TB no further intervention is required. Every third year, staff will be required to have chest xray regardless of results of the follow up questionnaire. (Attachment H)Person Responsible: Facility Nurse</p>	12/02/2011	

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	<p>Review on 11/01/11 at 11:15 AM of staff #1's personnel records indicated staff #1 had a chest X-ray on 1/23/09. Staff #1 had not had a chest x-ray since then and there was no checklist to document any negative or positive symptoms since 2009. Staff #1's hire date was 12/14/07.</p> <p>Interview on 11/01/11 at 11:20 AM with the facility nurse was conducted. The nurse indicated staff #1 hadn't had a chest x-ray since 1/23/09 and there was no checklist done by staff #1 annually after that.</p> <p>9-3-3(e)</p>				