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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G483 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 11/30/2012 |
| NAME OF PROVIDER OR SUPPLIER HOPEWELL CENTER INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILLSTREAM ROAD ANDERSON, IN 46011 | | |
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| W0000 | <p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Survey Dates: November 27, 28, 29 and 30, 2012.</p> <p>Surveyor: Kathy J. Wanner, Medical Surveyor III.</p> <p>Facility Number: 000997 Provider Number: 15G483 AIMS Number: 100249410</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed December 6, 2012 by Dotty Walton, Medical Surveyor III.</p> | W0000 | | | |

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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| W0140 | <p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview, the facility failed to give a full accounting of 1 additional client's (client #5's) personal funds.</p> <p>Findings include:</p> <p>Facility records including the Bureau Of Developmental Disabilities Services (BDDS) reports for the past year were reviewed on 11/28/12 at 12:52 P.M. indicating the following:</p> <p>A BDDS report dated 5/30/12 for 5/29/12 at 5:00 P.M. indicated, "Staff noted \$20.00 missing from [client #5's] petty cash during shift count during the evening shift count on 5/29/12. The Qualified Mental Retardation Professional (QMRP) is investigating if money was taken out for [client #5] to use when he went home, bowling, etc. within the last few days, that was not logged out. QMRP is also talking with the staff who did the shift counts. Hopewell is replacing the \$20.00 during the investigation."</p> <p>A follow-up BDDS report dated 6/6/12 indicated, "QMRP conducted an</p> | W0140 | <p>W140- As stated in interview with the QMRP this incident of missing funds for client #5 occurred in May 2012. During the investigation, it was determined that house manager was not following agency financial protocol which mandates 2 individuals must be present at each shift count of each residents personal funds.. House manager was released from employment for failure to follow company policies. To ensure future compliance with W140 for client #5 and all other residents, direct care staff re-trained in agency financial protocols for handling resident funds. Additional protocol added which restricts resident personal petty cash to no more than \$20 at any one time. Any funds in excess of this amount must be deposited to residents personal bank account. Additionally, facility increased oversight of resident personal funds by requiring new house manager to verify 2 staff initials are recorded at each shift count. QMRP to verify correct procedures are being implemented during routine house visits. Although internal investigation was inconclusive, provider</p> | 12/18/2012 | | | |

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| | <p>investigation which included interviewing each staff that completed shift counts on 5/28/12 and 5/29/12...QMRP also interviewed the house manager. QMRP reviewed the money ledgers and the amount in resident's money pouch. QMRP spoke with [client #5's] mother/guardian who confirmed that [client #5] did not have any extra money at her home on 5/28/12. The investigation proved inconclusive with regards to the missing \$20.00. However, it did determine through investigation procedures for having two staff actively participate in shift counts was inconsistent as one person was completing the shift count at times."</p> <p>The Procedures For Shift Count dated 6/12 was reviewed on 11/28/12 at 2:22 P.M. indicating: "Two shift counts should occur daily (A.M. and P.M.). Two staff must be actively involved accounting each residents (sic) funds. Staff initials verify that the amount on the ledger sheet agrees with the amount they have counted. Each staff should initial for themselves only. The House Manager (HM) or the QMRP should be notified immediately if there are any discrepancies between the last entry on the ledger and the actual money present. If during shift count, client intervention is needed, shift count should be stopped, money locked,</p> | | <p>immediately reimbursed client #5 \$20.00 for the missing resident funds. Persons Responsible: House Manager and QMRP Completion Date: 6-8-12</p> | | | | |

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| | <p>and the count should resume when the client situation is resolved."</p> <p>The Residential Manager (RM) was interviewed on 11/28/12 at 7:39 P.M. The RM stated, "We both, two people definitely, count it. We were retrained. Even if it comes out being off a penny I notify [name of QMRP]. We also have less money on hand now."</p> <p>The QMRP was interviewed on 11/29/12 at 3:43 P.M.. The QMRP stated, "No, we never did figure out where the missing money went. He (client #5) was paid back right away by check. The staff were already supposed to be counting the money with two staff present, but they didn't always do it that way. We tightened up the process."</p> <p>9-3-2(a)</p> | | | | |

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| W0322 | <p>483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. Based on record review and interview, the facility failed to address a follow-up recommendation for 1 of 4 sampled clients (client #1) who was referred to an ENT (Ear, Nose and Throat Specialist) at the time of his hearing evaluation.</p> <p>Findings include:</p> <p>Client #1's records were reviewed on 11/29/12 at 12:50 P.M.. Client #1 had a hearing evaluation dated 4/11/12. The evaluation indicated client #1 had "Mild nerve loss in his right ear." The hearing evaluation indicated, "ENT evaluation may be advised." There was no ENT evaluation available for review.</p> <p>The Qualified Mental Retardation Professional (QMRP) was interviewed on 11/29/12 at 2:40 P.M. The QMRP indicated client #1 had not been evaluated by an ENT.</p> <p>The LPN was interviewed on 11/29/12 at 2:45 P.M. The LPN stated, "They diagnosed the mild nerve loss. Not sure why he was to go to the ENT, but he did not go to the ENT. Normally they (the doctor's office) would make the referral and contact me. Usually I would</p> | W0322 | <p>W0322-To assure compliance with W322, client # 1 has appointment with ENT on 1-3-13. To assure ongoing compliance with W322 for client # 1 and all other residents, facility nurse to implement use of new tracking form for all MD and ancillary service referrals and recommendations. (Attachment A) The use of this form should more easily track follow up and completion of referrals. Facility nurse to submit completed tracking form to QMRP on a monthly basis. Additionally provider to increase RN consultaion services to provide additional chart review oversight to ensure all follow ups and recommendations have been completed and results have been received and charted. Persons Responsible: Facility Nurse Completion date: 12-18-12</p> | 12/18/2012 | | | |

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| | <p>follow-up if I did not hear anything about the referral to see if they had made the appointment.</p> <p>9-3-6(a)</p> | | | | |

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| W0339 | <p>483.460(c)(4) NURSING SERVICES Nursing services must include other nursing care as prescribed by the physician or as identified by client needs.</p> <p>Based on record review and interview, the facility failed to implement a post head trauma protocol for 1 of 4 sampled clients (client #4) who had seizures which resulted in head injuries.</p> <p>Findings include:</p> <p>Facility records including the Bureau Of Developmental Disabilities Services (BDDS) reports for the past year and the Internal Accident and Illness (A & I) reports for the past six months were reviewed on 11/28/12 at 12:52 P.M. indicating the following:</p> <p>An A & I report dated 6/12/12 at 8:50 P.M. indicated "[Client #4] had a seizure while walking, had some head wounds, applied ice for about 5 (five) minutes. Cleaned wound with wound cleanser, applied ointment. [Client #4] fell sideways hitting his head and shoulder on floor..." The 6/12/12 nurse's note indicated "Examined abrasion on top of head approx. (approximately) size of quarter. Red, dry, scabbed area. Slight swelling at temple c/ (with) light blue line (bruise) where site hit floor. Slight (light purple) bruising noted on side of left arm</p> | W0339 | <p>W339- Although there was no written head trauma protocol for client #4, it should be noted that he did have specific risk plans in place for both seizures and for falls. Nursing and service notes indicate that the established risk plans were followed in the above cited instances. To assure future compliance with W339 for client #4 as well as all other residents, facility nurse has now developed written post head trauma protocol. (attachments B,C,D) Protocol will be implemented for any fall accident that results in a trauma to the head. Nurse to provide training to staff on new head trauma protocol on 12-20-12. Person responsible: Facility nurse</p> | 12/20/2012 | | | |

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| | <p>at top. No tx (treatment) needed." The report did not indicate if neurological checks had been completed, or how staff were to monitor client #4 for any post head trauma symptoms.</p> <p>An A & I report dated 7/10/12 at 6:45 P.M. indicated "Client (client #4) was walking when he had a seizure falling forward on his hands and head causing an abrasion on his forehead and knuckles and finger." The 7/11/12 nurse's note indicated "Examined area on [client #4's] forehead. Area approx. size of (fifty cent) piece. Abraised, red, some light pink drng. (drainage) noted on bandage, No swelling or bruising noted. Small abrasion approx. 1/8" (one eighth of an inch) to knuckle and finger. ATB (anti-bacterial ointment) applied and Band-Aid. No further tx (treatment) needed. Instructed staff on tx for area on forehead." The report did not indicate if neurological checks had been completed, or how staff were to monitor client #4 for any post head trauma symptoms.</p> <p>A BDDS report dated 7/19/12 for 7/18/12 at 8:30 P.M. indicated client #4 was "leaving a [name of fair]and when walking to the van had a seizure and fell." Client #4 had a nose bleed and an abrasion to his nose. Client #4 was taken to the local ER. Client #4 also had</p> | | | | | | |

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| | <p>abrasions to his knees, finger and nose. The ER doctor contacted client #4's Neurologist and he made no medication changes. The report did not indicate if staff monitored client #4 for any post head trauma symptoms.</p> <p>An A & I report dated 10/23/12 at 6:35 P.M. indicated "Client (client #4) was being assisted in the shower when he had a seizure causing him to fall to his right side. While falling client struck right side of the back of his head resulting in a bump." The 10/24/12 nurse's note indicated "Examined back of head. Small nickel size dk. (dark) red area on right side of back of head. No bruising or drainage. Slight amount of swelling at site. Instructed (staff) to use ice pack or Tylenol (pain) if c/o (complained of) discomfort. No further tx needed." The report did not indicate if neurological checks had been completed, or how staff were to monitor client #4 for any post head trauma symptoms.</p> <p>An A & I report dated 10/31/12 at 10:25 A.M. indicated "Client (client #4) had a seizure in the bathroom and fell onto left side. Received a bruise from head hitting the wall. Abrasion possibly from fingernails. Nurse notified." The 11/1/12 nurse's note indicated "Examined [client #4's] head for injuries. Noted thin red</p> | | | | | | |

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| | <p>scratch 1" (one inch) long to upper temple on right side of head c/ (with) light purple faint bruising at site. No tx needed. Denies discomfort." The report did not indicate if neurological checks had been completed, or how staff were to monitor client #4 for any post head trauma symptoms.</p> <p>Client #4's record was reviewed on 11/29/12 at 2:11 P.M. indicating the following: Client #4's Physician's Order (PO) dated for the upcoming month, 12/2012, indicated his diagnoses included, but were not limited to, "Mental Retardation, Cerebral Palsy, Seizure Disorder and Epileptic Disorder. The PO indicated client #4 was to wear his VNS (Vagal Nerve Stimulator) magnet, his medical alert necklace, and his helmet daily during all waking hours." Client #4's record indicated he had a Helmet Wearing Procedure dated 5/18/11, Risk Plan for Falling dated 7/7/12, Risk Plan for Seizures 11/30/11. Client #4's record did not include a protocol for how staff should monitor client #4 after he suffered an injury to his head.</p> <p>The Residential Manger (RM) was interviewed on 11/28/12 at 7:39 P.M. The RM stated, "I think it would possibly be a good idea to have something in place to help staff know what to watch for after a</p> | | | |

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| | <p>head injury."</p> <p>The Qualified Mental Retardation Professional (QMRP) was interviewed on 11/29/12 at 3:20 P.M. The QMRP stated, "I think it would be good to have one in place. It seems kind of obvious now, not sure why we didn't have protocols in place before."</p> <p>The LPN was interviewed on 11/29/12 at 3:35 P.M. The LPN stated, "Anytime he is awake he should have his helmet on. We did get a new helmet which is full coverage, the prior one was like a halo type. Staff have not been trained on doing neuro. (neurological) checks. If there is a knot or any bleeding staff call me right away. If he comes out of a seizure and is able to give his name, answer questions, and no complaint of pain, they notify me the next morning." The LPN stated, "The staff know all the guys really well and would let me know if one of them was acting unusual." The LPN indicated a post head trauma protocol would be beneficial.</p> <p>9-3-6(a)</p> | | | | |