

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G726	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2013
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W000000	<p>This visit was for an annual recertification and state licensure survey.</p> <p>Dates of Survey: January 29, 30 and February 15, 2013.</p> <p>Facility number: 004789 Provider number: 15G726 AIM number: 200827230</p> <p>Surveyor: Christine Colon, Medical Surveyor III/QMRP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed March 1, 2013 by Dotty Walton, Medical Surveyor III.</p>	W000000		

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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W000104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview, the governing body failed for 6 of 6 clients (clients #1, #2, #3, #4, #5 and #6) living at the group home, to exercise general operating direction in a manner to ensure routine maintenance was completed.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 1/29/13 from 5:50 A.M. until 7:50 A.M. Upon entering the living room of clients #1, #2, #3, #4, #5 and #6's home, the ceiling light fixture had two light bulbs not working. The living room carpeting had stains throughout. The light fixture over the island in the kitchen had 1 of 3 light bulbs not working.</p> <p>An evening observation was conducted at the group home on 1/30/13 from 5:20 P.M. to 7:00 P.M. The ceiling light fixture had two light bulbs not working. The living room carpeting had stains throughout. The light fixture over the island in the kitchen had 1 of 3 light bulbs not working.</p> <p>An interview with Direct Support</p>	W000104	<p>The living room carpet is in the agency's capital budget for the year. It was budgeted to be replaced before June 30, 2013. Bids are being recieved at this time to replace the carpeting. The light bulbs have been replaced and management has been reminded to replace bulbs immediately when they burn out. Future compliance will be monitored through monthly house visits by the QDDP-D and the Lead Manager. Amended 3/22/13 Attached is the signed bid documenting that the floor is being replaced. The system in place to monitor is home maintenace is that the group home manager submits maintenance requests to the maintenance department when repairs are needed. In addition the Lead Manager and QDDP monitor this at monthly visits. As stated previously this item was listed on our capital budget to be replaced before June (this is also attached) and we were in the process of getting bids for replacing the floor in this home and other homes, so the issue was being addressed.</p>	03/17/2013	

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	<p>Professional (DSP) #3 was conducted on 1/30/13 at 6:55 P.M. DSP #3 indicated the light bulbs needed to be changed. DSP #3 indicated the carpet had stains.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 2/15/13 at 3:30 P.M. The QMRP indicated the mentioned items needed to be fixed.</p> <p>9-3-1(a)</p>			

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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 1 of 1 investigation reviewed, for 1 of 4 sampled clients (client #4), the facility neglected (failed to modify luncheon foods into small pieces) to prevent client #4 from choking.</p> <p>Findings include:</p> <p>A review of the facility's investigation records was conducted on 1/29/13 at 10:20 A.M. The review of 1 of 1 investigation record submitted for review indicated:</p> <p>"[Client #4]: Findings: Substantiated: Date of Investigation: 3/31/12 Type of Allegation: Neglect Date of Alleged incident: 3/30/12.</p> <p>Summary of Allegation: [Client #4] choked on her lunch at the workshop (facility operated) and an investigation was initiated to determine if it had been packed properly and checked according to the house procedures.</p> <p>Internal incident/accident report dated 3/30/12: "[Client #4] was seated eating lunch and turned slightly pale. [Client</p>	W000149	<p>After the incident occurred proper policy was followed in regards to conducting an investigation. The staff were retrained on 4/5/12 and 4/6/12 on dining plans and the lunch check procedure. There have been no further occurrences. To ensure ongoing compliance the QDDP-D and Lead Manager will continue to conduct monthly house visits. Amended 3/22/13 The dates of the training that was done are correct. The incident that led to this citation occurred on 3/30/12 and the training was done on 4/5/12 and 4/6/12. As stated previously there have been no further incidents since the training occurred. To ensure ongoing compliance, the group home manager is in the home monitoring meals at least three times a week. The Lead Manager and QDDP also conduct monthly visit to ensure complaince. As there have been no further incidents this monitoring system and the training that was conducted when the incident occurred appears to be working.</p>	03/17/2013	

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	<p>#4] leaned over her dish and food came out and pured (sic) into the dish. [Client #4] then took a deep breath in after the food was out of her throat. [Client #4] alert and responsive. Voice was raspy. [Client #4] continued to cough. Sent to ER (Emergency Room) for evaluation."</p> <p>Investigative summary:</p> <p>[Staff #10]: [Staff #10] states that she did not assist in packing [client #4's] lunch on the evening of 3/29/12 because [client #4] had been at AHA club (social club) and was not home at the time the GH ate dinner and packed lunches. The other staff on shift was [staff #14]. [Staff #10] states that it is common for there to be cheese sticks in the home and [client #4] has eaten them before with no problem.</p> <p>[Staff #11]: [Staff #11] worked the morning of 3/30/12 and states that it is her understanding the consumer lunches get checked by staff the (sic) in the evening when the lunches are packed. She states she did not check it on the morning of 3/30/12.</p> <p>[Staff #12]: [Staff #12] states that staff are supposed to check the lunch and document such (sic) check sheets, at the time the consumer lunch is packed in the evening and again in the morning by staff</p>						

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	<p>before the consumer goes out the door. [Staff #12] is unaware if the other morning staff checked the lunches (she couldn't remember her name stating she was new) but she knows that she did not check [client #4's] lunch.</p> <p>[Staff #13]: [Staff #13] is the previous Asst. (assistant) Manager who trained [staff #10]. She states that she showed [staff #10] where the lunch check documentation sheet was but doesn't recall specifically telling her that morning staff is to check the lunches as they were training on an evening shift."</p> <p>A review of the facility's "Universal Policies and Procedures-Adult Services-Abuse and Neglect" policy was conducted on 1/29/13 at 11:00 A.M. Review of the policy indicated: "Opportunity Enterprises, Inc. does not condone and will not tolerate physical, verbal or sexual abuse, neglect or exploitation of individuals served...Definition-Neglect: Includes the refusal or failure to provide appropriate care, food, medical care or supervision."</p> <p>A review of client #4's record was conducted on 1/30/13 at 3:45 P.M. Review of client #4's most current Nutritional Assessment dated 6/6/12 indicated she was on a regular diet with</p>			

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	<p>bite sized pieces.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 2/15/13 at 3:30 P.M. The QMRP indicated staff should have followed each client's prescribed diet. The QMRP stated "[Client #4's] cheese stick should have been cut into bite size pieces because of her possibly choking."</p> <p>9-3-2(a)</p>			

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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <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 for 2 of 3 sampled clients (#1 and #2), and 1 additional client (#5), the facility failed to ensure the clients received a continuous active treatment program by staff failing to implement client programs.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 1/29/13 from 5:50 A.M. until 7:00 A.M. During the entire observation period, clients #2 and #5 did not communicate and were not prompted to communicate. Staff did not prompt client #5 to make a complete sentence. Client #2 did not utilize communication cards during the observation period. Client #1 stayed in her room during the entire observation period. Client #1 did not choose from a basket of magazines which were to be earned if she completed her morning routine.</p> <p>An evening observation was conducted at</p>	W000249	<p>The staff will be retrained on the consumer's ISPs and the BSP for consumer #1. This training will emphasize the importance of following ISPs and BSP. The group home manager will nomintor staff on an ongoing basis to ensure staff are following the ISPs and BSPs. To ensure future compliance the QDDP-D and Lead Manager will conduct monthly house visits.Amended 3/22/13The group home manager is in the home at least three times a week monitoring active treatment. The QDDP-D will remind all group home managers of their duty to monitor for active treatment on an ongoing basis and to retrain staff when deficiencies in this area is noted. The Lead Manager and QDDP-D will monitor monthly at house visits to ensure compliance.</p>	03/17/2013			

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	<p>the group home on 1/30/13 from 5:20 P.M. until 7:00 P.M. During the entire observation period, clients #2 and #5 did not communicate and were not prompted to communicate. Staff did not prompt client #5 to make a complete sentence. Client #2 did not utilize communication cards during the observation period. Client #1 stayed in her room during the entire observation period.</p> <p>A review of client #1's record was conducted at the facility's administrative office on 1/30/13 at 1:30 P.M. Review of client #1's Individual Support Plan (ISP) dated 4/5/12 indicated the following objectives which were not implemented: "Will get napkins for dinner table...Will state the name of the coin...Will write name...Will empty vegetable in bowl at dinner." Review (1/30/13 1:30 P.M.) of her Behavior Support Plan dated 12/28/12 indicated: "In the morning when she gets up, [client #1] can choose from a basket of magazines which magazine she would like to earn if she completes her morning routine without behaviors. Staff will explain to [client #1] that the magazine will be placed on the dining room table at her place setting."</p> <p>A review of client #2's record was conducted at the facility's administrative office on 1/30/13 at 2:00 P.M. Review of</p>				

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	<p>client #2's ISP dated 5/30/12 indicated the following objectives which were not implemented: "Will utilize 3 communication cards that show the picture and the sign. When [client #2] is asking for something she should be prompted to use her cards...[Client #2] should be encouraged to go through her cards. Staff will say the word to [client #2] and point to the picture and sign...Will id (identify) each coin in a lineup."</p> <p>A review of client #5's record was conducted at the facility's administrative office on 1/30/13 at 4:00 P.M. Review of client #5's Individual Support Plan dated 1/17/13 indicated the following objectives which did not get implemented: "Will id quarters in a pile of change...Will make a complete sentence in morning and evening with verbal prompts."</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted at the facility's administrative office on 2/15/13 at 3:30 P.M. The QMRP indicated staff should implement each clients' objectives "at all times of opportunity."</p> <p>9-3-4(a)</p>						

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W000436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>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.</p> <p>Based on observation, record review, and interview, for 1 of 3 sampled clients (client #3) who was recommended the use a hearing aid, the facility failed to furnish a hearing aid.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 1/29/13 from 5:50 A.M. to 7:50 A.M. Client #3 did not wear hearing aids during the entire observation period. Staff did not prompt client #3 to wear hearing aids.</p> <p>An evening observation was conducted at the group home on 1/30/13 from 5:20 P.M. to 7:00 P.M. Client #3 did not wear hearing aids during the entire observation period. Staff did not prompt client #3 to wear hearing aids.</p> <p>A day program observation was conducted on 1/30/13 from 12:30 P.M. to 1:00 P.M. Client #3 did not wear hearing aids during the observation period. Staff did not prompt client #3 to wear hearing</p>	W000436	<p>Client # 3's hearing evaluation dated 10/28/10 stated hearing aid was recommended for left ear. This recommendation was discussed at the IDT meeting on 11/16/10 and it was decided by the team that Client # 3 was not showing signs that she could not hear. Since that date, Client # 3 has had annuals completed and it states on each one that she is not having hearing difficulties. The team closely monitors Client # 3 for any signs that she is having difficulty hearing and none have been noted. Client # 3 will follow up with her next hearing evaluation in October 2013. To ensure ongoing compliance as was done in this case, the IDT will discuss all physician recommendations and follow up as needed. The QDDP-D will monitor to ensure compliance. Amended 3/22/2013 This consumer does not have an objective to wear hearing aids, the current ISP is attached to support this. Also attached is the monthly summary for 11/2010 documenting that the hearing aid was discussed by the team and they felt she was not showing any</p>	03/17/2013			

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	<p>aids.</p> <p>A review of client #3's record was conducted on 1/30/13 at 2:28 P.M. A review of client #3's Individual Support Plan dated 5/22/2012, indicated: "Adaptive equipment: [Dr. name] ordered orthotic inserts for her shoes due to flat feet. [Client #3] also uses a C-Pap machine at night to assist with her breathing and sleeping due to sleep apnea." Further review of the ISP did not indicate the use of hearing aids. A review of client #3's most current audiological exam dated 10/28/10 indicated: "Excessive wax was removed from both ear canals. She has holes in both eardrums. Results of testing revealed a moderate to mild conductive hearing loss in right ear and a severe to moderate conductive hearing loss in left ear. Hearing aid is recommended for left ear...Return in 3 years."</p> <p>The Qualified Mental Retardation Professional (QMRP) was interviewed at the facility's administrative office on 2/15/13 at 3:30 P.M. The QMRP indicated client #3 did not have hearing aids as recommended by the audiologist.</p> <p>9-3-7(a)</p>		<p>signs of hearing loss. In addition the annual physicals form 12/2010, 12/2011 and 1/2013 documenting the there are no hearing problems noted.</p>				

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