

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G299	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/31/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1807 W PORTER AVE CHESTERTON, IN 46304
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W000000	<p>This visit was for the investigation of Complaint #IN00137330.</p> <p>Complaint #IN00137330: SUBSTANTIATED, Federal and state deficiencies related to the allegations are cited at W149, W154, W157 and W218.</p> <p>Dates of survey: October 9, 10, 11 and 31, 2013</p> <p>Facility number: 000818 Provider number: 15G299 AIM number: 100234990</p> <p>Surveyor: Christine Colon, QIDP</p> <p>The following deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/26/13 by Ruth Shackelford, QIDP.</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G299		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/31/2013	
NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1807 W PORTER AVE CHESTERTON, IN 46304			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
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, the facility neglected to implement their abuse/neglect policy for 1 of 3 sampled clients and 1 additional client, (clients C and F), to conduct thorough investigations in regards to injuries of unknown origin.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted on 10/9/13 at 2:00 P.M.. Review of the facility's internal incident reports and Bureau of Developmental Disabilities Services (BDDS) reports indicated:</p> <p>1. -Internal incident report dated 9/15/13 involving client C: "I was not in the room when [client C] fell. I heard whimpering from the hallway. I went into her and another consumers room which has an attached bathroom. [Client C] was laying on her back on the floor in the bathroom. She did not have any lights on while using the restroom."</p> <p>2. -Internal incident report dated 8/19/13 involving client F: "The injury</p>	W000149	<p>All incident reports will be thoroughly investigated to rule out abuse/neglect and the QDDP had been retrained on how to document these investigations. All documentation from the investigation will be included in the report. All written notes will be transcribed in the report. Future compliance will be ensured by the monitoring of group home incident reports by the Vice President of Consumers Services as they completed and submitted. Addendum:All incident reports regarding injuries of unknown origin will be thoroughly investigated to rule out any type of abuse/neglect – this will be conducted through investigations by the QDDP-D. All information from the investigation will be documented in the BDDS/incident report. To ensure future compliance, on 12/19/13, the QDDP-D will be retrained on OE's incident reporting policy as well as "The components of a thorough investigation". The staff as well as the QDDP-D will be trained on Opportunity Enterprises Abuse/neglect by 12/23/13. On an ongoing basis, the SGL QDDP-D manager will review all incident reports to confirm a thorough investigation</p>	12/08/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G299	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/31/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1807 W PORTER AVE CHESTERTON, IN 46304
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>was found as [client F] was finishing breakfast. There is a patch of skin about the size of a nickel that is peeled off the back of her left hand. Earlier in the month, there had been a few really small scratches in that same area that were recorded on the body check form that appeared to be from her nails. It is now an entire patch of missing skin that was not missing before she went to bed."</p> <p>A review of client C's record was conducted at the facility's administrative office on 10/11/13 at 1:40 P.M.. Review of client C's record indicated she was non-verbal.</p> <p>A review of client F's record was conducted at the facility's administrative office on 10/11/13 at 2:40 P.M.. Review of client F's record indicated she was non-verbal.</p> <p>A review of the facility's policy titled, "Universal Policies and Procedures, Adult Services, Policy #: 6012 - Abuse and Neglect" dated 4/14/10, was conducted on 10/11/13 at 2:30 P.M. and indicated, "...does not condone and will not tolerate physical, verbal or sexual abuse, neglect or exploitation of individuals served." Physical abuse was defined as "Includes willful infliction of injury, unnecessary physical or chemical</p>		was properly completed for injuries of unknown origin.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G299	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/31/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1807 W PORTER AVE CHESTERTON, IN 46304
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>restraints or isolation, and punishment with resulting physical harm or pain. Physical abuse may include battery: to knowingly or intentionally touch another person in a rude, insolent or angry manner." Neglect was defined as "Includes the refusal or failure to provide appropriate care, food, medical care, or supervision. Knowingly placing a client in a situation that may endanger his/her life or health; abandoning or cruelly confining a client; depriving a client of necessary support including food, clothing, shelter or medical care...Investigations, may include, but is not limited to, a statement from the complainant, a statement from the alleged violator and a statement from witnesses to the alleged incident. Statements may be written or verbal depending on the circumstances of the investigation, All verbal statements will be recorded and maintained as part of the confidential file. Employees will be asked to sign a confidentiality statement after being interviewed about the alleged incident. All material collected during the course of the investigation shall remain confidential. Any breach in confidentiality will result in disciplinary action...A report of the information collected during the investigation will be sent to the Day Services Senior Director or the Vice President of Consumer</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G299		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/31/2013	
NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1807 W PORTER AVE CHESTERTON, IN 46304			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Services within 5 working days following the report of the incident."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted at the facility's administrative office on 10/11/13 at 2:50 P.M.. When asked if there was any written documentation to show investigations were conducted, the QIDP indicated there was no written documentation to indicate any investigations were conducted. When asked if all staff who worked at the group home had been interviewed, the QIDP stated, "No, just the staff who worked on the dates of the incidents." When asked if all clients were interviewed, the QIDP stated "No." The QIDP further indicated she did not have any notes/documentation she obtained when interviewing scheduled staff because she discards her notes/documentation after submitting incident reports.</p> <p>This federal tag relates to complaint #IN00137330.</p> <p>9-3-2(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G299	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/31/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1807 W PORTER AVE CHESTERTON, IN 46304
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 2 of 7 Bureau of Developmental Disabilities Services reports (BDDS)/Internal incident reports reviewed involving 1 of 3 sampled clients and 1 additional client, (clients C and F), the facility failed to provide evidence of thorough investigations.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted on 10/9/13 at 2:00 P.M.. Review of the facility's internal incident reports and BDDS reports indicated:</p>	W000154	Please see plan of correction for W149. See addendum for W149.	12/08/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G299		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/31/2013	
NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1807 W PORTER AVE CHESTERTON, IN 46304			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>1. -Internal incident report dated 9/15/13 involving client C: "I was not in the room when [client C] fell. I heard whimpering from the hallway. I went into her and another consumers room which has an attached bathroom. [Client C] was laying on her back on the floor in the bathroom. She did not have any lights on while using the restroom."</p> <p>2. -Internal incident report dated 8/19/13 involving client F: "The injury was found as [client F] was finishing breakfast. There is a patch of skin about the size of a nickel that is peeled off the back of her left hand. Earlier in the month, there had been a few really small scratches in that same area that were recorded on the body check form that appeared to be from her nails. It is now an entire patch of missing skin that was not missing before she went to bed."</p> <p>A review of client C's record was conducted at the facility's administrative office on 10/11/13 at 1:40 P.M.. Review of client C's record indicated she was non-verbal.</p> <p>A review of client F's record was conducted at the facility's administrative office on 10/11/13 at 2:40 P.M.. Review of client F's record indicated she was non-verbal.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G299	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/31/2013
NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1807 W PORTER AVE CHESTERTON, IN 46304		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted at the facility's administrative office on 10/11/13 at 2:50 P.M.. When asked if there was any written documentation to show investigations were conducted, the QIDP indicated there was no written documentation to indicate any investigations were conducted. When asked if all staff who worked at the group home had been interviewed, the QIDP stated, "No, just the staff who worked on the dates of the incidents." When asked if all clients were interviewed, the QIDP stated "No." The QIDP further indicated she did not have any notes/documentation she obtained when interviewing scheduled staff because she discards her notes/documentation after submitting incident reports.</p> <p>This federal tag relates to complaint #IN00137330.</p> <p>9-3-2(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G299	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/31/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1807 W PORTER AVE CHESTERTON, IN 46304
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 1 of 3 sampled clients, (client C), the facility failed to put in place corrective actions/measures to prevent falls.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted on 10/9/13 at 2:00 P.M.. Review of the facility's internal incident reports and BDDS reports indicated:</p> <p>-Internal incident report dated 9/15/13 involving client C: "I was not in the room when [client C] fell. I heard whimpering from the hallway. I went into her and another consumers room which has an attached bathroom. [Client C] was laying on her back on the floor in the bathroom. She did not have any lights on while using the restroom."</p> <p>-BDDS report dated 8/27/13 involving client C: "[Client C] was walking down</p>	W000157	Please see plan of correction for W149. In addition, high risk protocols will be updated annually or as needed by the nurse should an issue arise. If an incident occurs, the high risk protocol will be reviewed by the team and the nurse will make any needed changes. The QDDP will then ensure the revised plan is implemented, including staff training. The QDDP will then monitor the implemetation of the protocol through monthly observations in the day program and during house visits. Addendum:High risk protocols are updated annually and as needed. QDDP-D ensures staff is properly trained with updated high risk protocols. On 12/9/13 the night light checklist was initiated for client C and all staff was trained by the QDDP-D on the night light check list and ensuring all night lights are in proper working order. On an ongoing basis the QDDP-D will check during monthly visits that the lights are being utilized and	12/08/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G299		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/31/2013	
NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1807 W PORTER AVE CHESTERTON, IN 46304			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>the hallway outside ADC (day program) headed toward the exit. She tripped on the edge of a long rug in front of the first door. When she fell, she did not put her hands out in front of her to break her fall she fell onto her face. GHAM (Group Home Assistant Manager) was standing 2 feet from her when the fall occurred. She helped [client C] onto her side and asked her if she was ok. She just looked at her and made no sound. [GHAM] asked her if she could roll her over to her back to get a better look at her, she gave no response. Once she rolled [client C] over to her back she noticed she had a large abrasion on her forehead and down the bridge of her nose. Her nose was not bleeding at this time. [GHAM] asked [client C] if she was ok, she just made a slight sound. She asked if she could sit up she made no attempt. [GHAM] assisted in sitting her up. At that time [Manager] was standing next to her and was asking [client C] if she was ok. [GHAM] asked [client C] if she could stand up, she just made a noise. She explained to [client C] that she was going to help her stand up. [GHAM] placed both arms underneath hers around her torso and attempted to help her stand up. Once she had her up she would not bare weight on her legs to stand. [Manager then helped [GHAM] stand [client C] up and placed her in a</p>		<p>they are in proper working order. To ensure further compliance on 12/19/13 QDDP-D reviewed all participants' records to determine if any further evaluations are needed. Beginning January 1st IDT documentation will formally include a section to discuss high risk protocols and comprehensive functional assessments and what is needed. The IDT will discuss health and safety and ensure appropriate action is taken. If more testing, documentation, or evaluating is necessary; the QDDP-D will make certain that it is implemented for the protection of each participant. The Vice President of Consumer Services will monitor montly summaries to ensure compliance.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G299		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/31/2013	
NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1807 W PORTER AVE CHESTERTON, IN 46304			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>wheelchair to get her outside to the van. When asked if she was ok again she began making slight sounds but seemed disoriented. I got to the group home van and explained to [Staff] what happened. She called QDDP (Qualified Developmental Disabilities Professional) and said that [client C] would be going to the ER (Emergency Room). [Staff] and [GHAM] assisted [client C] in to [QDDP]'s car where she was taken to [Urgent Care]. [Doctor] diagnosed [client C] with a nasal fracture and 2 sprained wrists. Discharge instructions were to monitor [client C] throughout the night due to hitting her head...."</p> <p>A review of client C's record was conducted at the facility's administrative office on 10/11/13 at 2:10 P.M.. Review of client C's record indicated she was non-verbal. Review of client C's medical record indicated: "Fall Protocol...[Client C]...Date of Entry: 9/9/13...Issue Clarification: [Client C] is at high risk for falling." Review of client C's record failed to have an assessment that addressed her mobility needs. Further review of the record did not indicate any corrective action/measures were put in place to address client C's fall.</p> <p>An interview with the Qualified</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G299	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/31/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1807 W PORTER AVE CHESTERTON, IN 46304
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000218	<p>Intellectual Disabilities Professional (QIDP) was conducted at the facility's administrative office on 10/11/13 at 2:50 P.M.. When asked if any measures were put in place to address clients C's documented and/or possible falls, the QIDP indicated the client had a fall risk plan in place and staff were told to prompt the client on picking up her feet when walking to prevent falling. When asked if there was any documentation in the client's record to indicate corrective action/measures were put in place to address client C's falls, the QIDP indicated there was no corrective measures in the client's record.</p> <p>This federal tag relates to complaint #IN00137330.</p> <p>9-3-2(a)</p> <p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include sensorimotor development.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G299		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/31/2013	
NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1807 W PORTER AVE CHESTERTON, IN 46304			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Based on record review, observation and interview, for 2 of 3 sampled clients (clients A and C) with documented falls, the facility failed to complete sensorimotor assessments that addressed all of client A and C's mobility needs.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted on 10/9/13 at 2:00 P.M.. Review of the facility's internal incident reports and Bureau of Developmental Disabilities Services (BDDS) reports indicated:</p> <p>-BDDS report dated 10/6/13 involving client A: "Staff was in living room area with other clients when they heard a loud bang come from the bathroom down the hall. Upon entering the bathroom they saw [client A] on the floor with her back to the sink area. [Client A] said she tripped in the bathroom and hit her back on the corner of the sink are (sic). The floor was dry and upon further questioning [client A] said she tripped because of her walker. As a result of the fall [client A] has a 3 x (by) 2 inch bruise in the middle of her back. Staff contacted appropriate supervisor and reported the fall."</p> <p>-Internal incident report dated 9/15/13</p>	W000218	<p>Clients A and C are both scheduled to have PT evals completed on 12/11/13. Client A saw her podiatrist and she has been measured for a new AFO. To ensure future compliance, at monthly meetings and after incidents occur, the IDT will determine if any evaluations are needed when discussing any changes needed in the high risk protocols. The QDDP will monitor to ensure compliance. Addendum:All participants in the GH that had an incident of falling or utilize a walker completed PT evaluations on 12/11/13. The remaining 2 were reviewed and it was agreed that neither participant required any assessments at this time. To ensure compliance, beginning January 1st IDT documentation will formally include a section to discuss high risk protocols and comprehensive functional assessments and what is needed. The IDT will discuss health and safety and ensure appropriate action is taken. If more testing, documentation, or evaluating is necessary; the QDDP-D will make certain that it is implemented for the protection of each participant. The vice president of consumer services will monitor monthly summaries to ensure compliance.</p>	12/08/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G299	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/31/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1807 W PORTER AVE CHESTERTON, IN 46304
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>involving client C: "I was not in the room when [client C] fell. I heard whimpering from the hallway. I went into her and another consumers room which has an attached bathroom. [Client C] was laying on her back on the floor in the bathroom. She did not have any lights on while using the restroom."</p> <p>-BDDS report dated 8/27/13 involving client C: "[Client C] was walking down the hallway outside ADC (day program) headed toward the exit. She tripped on the edge of a long rug in front of the first door. When she fell, she did not put her hands out in front of her to break her fall (sic) she fell onto her face. GHAM (Group Home Assistant Manager) was standing 2 feet from her when the fall occurred. She helped [client C] onto her side and asked her if she was ok. She just looked at her and made no sound. [GHAM] asked her if she could roll her over to her back to get a better look at her, she gave no response. Once she rolled [client C] over to her back she noticed she had a large abrasion on her forehead and down the bridge of her nose. Her nose was not bleeding at this time. [GHAM] asked [client C] if she was ok, she just made a slight sound. She asked if she could sit up (sic) she made no attempt. [GHAM] assisted in sitting her up. At that time [Manager]</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G299		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/31/2013	
NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1807 W PORTER AVE CHESTERTON, IN 46304			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>was standing next to her and was asking [client C] if she was ok. [GHAM] asked [client C] if she cold stand up, she just made a noise. She explained to [client C] that she was going to help her stand up. [GHAM] placed both arms underneath hers around her torso and attempted to help her stand up. Once she had her up she would not bare (sic) weight on her legs to stand. [Manager] then helped [GHAM] stand [client C] up and placed her in a wheelchair to get her outside to the van. When asked if she was ok again she began making slight sounds but seemed disoriented. I got to the group home van and explained to [Staff] what happened. She called QDDP (Qualified Developmental Disabilities Professional) and said that [client C] would be going to the ER (Emergency Room). [Staff] and [GHAM] assisted [client C] in to [QDDP]'s car where she was taken to [Urgent Care]. [Doctor] diagnosed [client C] with a nasal fracture and 2 sprained wrists. Discharge instructions were to monitor [client C] throughout the night due to hitting her head..."</p> <p>A day program observation was conducted on 10/11/13 from 12:55 P.M. until 1:15 P.M.. During the observation period clients A and C were observed to have an unsteady gait and used walkers</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G299	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/31/2013
NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1807 W PORTER AVE CHESTERTON, IN 46304		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>to assist them in mobility.</p> <p>A review of client A's record was conducted at the facility's administrative office on 10/11/13 at 1:40 P.M.. Review of client A's medical record indicated: "Fall Protocol...[Client A]...Date of Entry 3/29/13...Issue Clarification: [Client A] is at high risk for falling, due to use of a wheeled walker and unsteady gait." Further review of client A's record failed to have an assessment that addressed her mobility needs.</p> <p>A review of client C's record was conducted at the facility's administrative office on 10/11/13 at 2:10 P.M.. Review of client C's medical record indicated: "Fall Protocol...[Client C]...Date of Entry: 9/9/13...Issue Clarification: [Client C] is at high risk for falling." Further review of client C's record failed to have an assessment that addressed her mobility needs.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted at the facility's administrative office on 10/11/13 at 2:50 P.M.. When asked if clients A and C had assessments completed to address their mobility needs, the QIDP stated "No they have not." When asked if any assessments had been completed to</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G299	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/31/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1807 W PORTER AVE CHESTERTON, IN 46304
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>address clients A and C's documented falls, the QIDP stated "No, there were not."</p> <p>This federal tag relates to complaint #IN00137330.</p> <p>9-3-4(a)</p>			