

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G512	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/27/2016
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NAME OF PROVIDER OR SUPPLIER OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383
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W 0000 Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: May 24, 25, 26, and 27, 2016.</p> <p>Facility number: 001026 Provider number: 15G512 AIM number: 100245160</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 6/3/16.</p>	W 0000		
W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview, the facility's governing body failed to exercise general operating direction over the facility by failing to ensure doors, molding, and hallway walls in the facility were in good repair for 3 of 3 sampled clients (clients #1, #2, and #3), and 3 of 3 additional clients (clients #4, #5, and #6).</p> <p>Findings include:</p>	W 0104	This deficient practice has affected all clients, in this group home. To correct this, the agency will replace the door on the medication administration room, along with the molding down the hallway and on the client bedroom entry doors. To ensure this deficient practice does not reoccur, the group home director and or QDDP will conduct monthly facility inspections to ensure that home remains in	06/24/2016

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>The group home where clients #1, #2, #3, #4, #5, and #6 resided was inspected during the 5/24/16 observation period from 4:08 P.M. until 6:00 P.M. The door to the medication room had three 3 inch holes in it. Doors and door molding to all client rooms had deep scratches with paint missing. These aforementioned areas of the facility were utilized by clients #1, #2, #3, #4, #5, and #6.</p> <p>Director of Residential Services #1 was interviewed on 5/26/16 at 9:22 A.M. Director of Residential Services #1 stated, "Maintenance is in charge of repairing these areas and is in the process of repairing them." When asked if a work order had been submitted for repairing the facility doors and associated moldings, Director of Residential Services #1 stated, No, I don't think so."</p> <p>9-3-1(a)</p>		<p>good repair. Documentation of these visits will be kept under the supervision of the group home director.</p>				
W 0157 Bldg. 00	<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, the facility failed to implement corrective</p>	W 0157	To ensure this deficient practice has not affected other clients, an	06/17/2016			

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	<p>action for 1 of 12 reviewed incident reports which involved 1 of 3 sampled clients (client #2) who had an incident of elopement.</p> <p>Findings include:</p> <p>The facility's records were reviewed on 5/24/16 at 10:35 A.M. Review of incident reports from 12/1/15 to 5/24/16 indicated the following elopement incident involving client #2:</p> <p>-"Individual Name (client name) [client #2], Event Date: 03/11/2016, Event Summary: As staff was unloading clients from the bus, [client #2] waited by the garage door to wait for a specific staffer. Staff was forced to move to follow another client and help clients indoors. Shortly after, [client #2] was escorted back to the group home by a civilian after attempting to leave instead of coming inside with everyone else." Further review of the 3/11/16 incident report indicated the report was reviewed by Director of Residential Services #1 on 3/14/16 who offered the following recommendations: "To immediately resolve this incident, [client #2] will be placed on a line of sight supervision, until further assessments can be completed. To address this long term, an elopement high risk protocol will be</p>		<p>audit was completed to ensure that all corrective measures, including the development of specialized protocols, were in place; no other clients were found to have been affected. An elopement protocol for client #2 has been developed and implemented. Staff are currently trained on this protocol and following its standards. To ensure this deficient practice does not reoccur, the QDDP and/or Group Home Director will audit client records, monthly, to ensure the accuracy of high-risk protocols.</p>	

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W 0249 Bldg. 00	<p>developed, reviewed and approved by the IRT (sic) (IDT, Inter-Disciplinary Team), and implemented."</p> <p>Client #2's record was reviewed on 5/26/16 at 8:30 A.M. Review of the client's record failed to indicate an elopement high risk protocol had been implemented.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 5/26/16 at 10:37 A.M. QIDP #1 stated, "We haven't implemented an elopement protocol for [client #2] yet."</p> <p>9-3-2(a)</p> <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, the facility failed to use a Hoyer (brand name) lift to transfer 1 of 3 sampled clients (client #2) as indicated in the client's record.</p>	W 0249	To ensure this deficient practice has not affected other clients, an audit was completed to ensure that all high-risk protocols, were up to date; no other clients were found to have been affected.	06/17/2016

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	<p>Findings include:</p> <p>Client #2 was observed at the group home during the 5/24/16 observation period from 4:08 P.M. until 6:00 P.M. At 5:45 P.M., direct care staff #1 and #4 physically lifted client #2 from his bed and placed the client into his wheel chair. During this transfer, a Hoyer lift was observed to be in client #2's bedroom but it was not utilized.</p> <p>Client #2 was observed at the group home during the 5/25/16 observation period from 5:44 A.M. until 7:15 A.M. At 6:20 A.M., direct care staff #5 and #6 physically transferred client #2 from the client's bed to his wheelchair. No Hoyer lift was used.</p> <p>Direct care staff #6 was interviewed on 5/25/16 at 7:20 A.M. When asked if staff were to use a Hoyer lift to transfer client #2 to and from his bed, direct care staff #6 stated, "We can either use the (Hoyer) lift or we can transfer him (client #2) physically."</p> <p>Client #2's records were reviewed on 5/25/16 at 8:30 A.M. A review of client #2's Hoyer lift safety protocol, dated 3/24/16, indicated "When [client #2] is in a reclining position in bed, the Hoyer lift</p>		<p>Client #2's protocol for using a Hoyer lift was updated, by the group home nurse, to include the option of staff lifting the client from his bed or using the Hoyer lift. Client #2 has expressed that he would rather be physically lifted, if possible, as opposed to using the Hoyer lift on every lift. To ensure this deficient practice does not re-occur, the QDDP will review the client's high-risk protocols, monthly, with the Group Home Registered Nurse, to ensure their accuracy; documentation of reviews will be housed in the QDDP's monthly IDT notes. On 6.17.16, the group home registered nurse trained all staff on the modified lifting protocol, for Client #2. To ensure safe lifting procedures are being followed, onsite monitoring will be conducted, once a day, for the duration of 5 consecutive days, by the QIDP and/or Group Home Manager. After the 5th visit, the QIDP and Group Home Nurse will jointly evaluate the need for continued daily visits. If it is determined that daily onsite checks are no longer needed, Client #2's lifting protocols will be monitored through two separate monthly visits; one by the QIDP and one by the group home registered nurse.</p>		

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W 0268 Bldg. 00	<p>will be utilized to help transfer [client #2] to his wheel chair."</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 5/26/16 at 10:37 A.M. QIDP #1 stated, "Staff (direct care staff) should have used the Hoyer lift."</p> <p>9-3-4(a)</p> <p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation and interview, the facility failed to assure 1 of 3 sampled clients (client #3) did not have excessive saliva dripping from his chin.</p> <p>Findings include:</p> <p>Client #3 was observed at the group home on 5/24/16 from 4:08 P.M. until 6:00 P.M. During the observation period, client #3 had excessive saliva dripping from his mouth and off of his chin and onto his shirt. Direct care staff #1, #2, #3, and #4 did not assist or prompt client</p>	W 0268	To ensure this deficient practice has not affected other clients, an audit was completed to ensure that all client ISPs, were up to date; no other clients were found to have been affected. Client #3's ISP was updating, by the QDDP, to include the goal of promoting the client to wipe his chin, when saliva becomes excessive. To ensure this deficient practice does not re-occur, the QDDP will review the client's ISP, monthly, with the Group Home Registered Nurse, to ensure the accuracy and need of the ISPs; documentation of reviews will be housed in the	06/24/2016

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	<p>#3 in wiping the excess saliva from his chin.</p> <p>Director of Residential Services #1 was interviewed on 5/26/16 at 9:22 A.M. Director of Residential Services #1 stated, "Staff (direct care staff) should have prompted or assisted him (client #3) in wiping off the excessive saliva." 9-3-5(a)</p>		<p>QDDP's monthly IDT notes. To ensure onsite compliance, the QIDP or group home manager, will conduct daily quality assurance checks, to ensure that Client #3's ISP goal is being implemented effectively. After 10 successful daily checks, the QDDP will evaluate the need for continued daily onsite monitoring. If it is determined that daily onsite monitoring is still needed, the QDDP will monitor for another 10 days and reassess. If continued daily monitored is not needed, the QIDP will monitor through onsite monthly visits. The QIDP will maintain all documentation.</p>	

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W 0448 Bldg. 00	<p>483.470(i)(2)(iv) EVACUATION DRILLS</p> <p>The facility must investigate all problems with evacuation drills, including accidents. Based on record review and interview, the facility failed to investigate issues noted during evacuation drills for 1 of 3 sampled clients (client #2).</p> <p>Findings include:</p> <p>The facility's records were reviewed on 5/25/16 at 8:28 A.M. Review of evacuation drills from 4/1/15 to 5/25/16 indicated the following evacuations and and the time it took for client #2 to evacuate the group home: 4/8/16 - 3 minutes, 4/4/16 - 3 minutes 53 seconds, 3/25/16 - 4 minutes 7 seconds, 3/15/16 - 3 minutes 45 seconds. Review of the 4/4/16 evacuation drill indicated client #2 was "hesitant" to leave the group home.</p> <p>The facility's records were further reviewed on 5/25/16 at 9:07 A.M. The review failed to indicate the aforementioned evacuation drills involving client #2 had been investigated.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 5/26/16 at 10:37 A.M. QIDP #1 stated, "I know it has taken [client #2] a lot longer to get out of the house when we</p>	W 0448	To ensure this deficient practice has not affected other clients, an audit was completed to ensure that all fire drill were investigated; no other clients were found to have been affected. Client #2's evacuation drill was investigated by the QDDP and Group Home Director, it was found that client 2 knows that the evacuation is drill, as opposed to a real emergency, and states that he would rather not evacuate. However, client 2 knows that it is in his best interest to practice the evacuation, in the case of emergency, and has been cooperative. To ensure this deficient practice does not re-occur, the QDDP and/or group home director will review all fire drills and investigate issues that are noted. Documentation and follow-up notes will be attached to the fire drill record.	06/17/2016

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W 0449 Bldg. 00	<p>have an evacuation drill, but no, none of [client #2's] evacuations from the group home have been investigated."</p> <p>9-3-7(a)</p> <p>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, the facility failed to implement corrective action for issues noted during evacuation drills for 1 of 3 sampled clients (client #2).</p> <p>Findings include:</p> <p>The facility's records were reviewed on 5/25/16 at 8:28 A.M. Review of evacuation drills from 4/1/15 to 5/25/16 indicated the following evacuations and and the time it took for client #2 to evacuate the group home: 4/8/16 - 3 minutes, 4/4/16 - 3 minutes 53 seconds, 3/25/16 - 4 minutes 7 seconds, 3/15/16 - 3 minutes 45 seconds. Review of the 4/4/16 evacuation drill indicated client #2 was "hesitant" to leave the group home.</p>	W 0449	<p>To ensure this deficient practice has not affected other clients, an audit was completed to ensure that all fire drill were investigated; no other clients were found to have been affected. Client #2's evacuation drill was investigated by the QDDP and Group Home Director, it was found that client 2 knows that the evacuation is drill, as opposed to a real emergency, and states that he would rather not evacuate. However,</p>	06/17/2016

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W 0473 Bldg. 00	<p>The facility's records were further reviewed on 5/25/16 at 9:07 A.M. The review failed to indicate the corrective action for client #2's evacuating the group home had been implemented.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 5/26/16 at 10:37 A.M. QIDP #1 stated, "No. No corrective action for [client #2] evacuating the group home in a timely manner has been implemented."</p> <p>9-3-7(a)</p> <p>483.480(b)(2)(ii) MEAL SERVICES Food must be served at appropriate temperature. Based on observation and interview, the facility failed to ensure a biscuit, gravy, and cheese casserole was served at an appropriate temperature, within 15 minutes upon removal from the temperature control device, affecting 3 of 3 sampled clients (clients #1, #2, and #3).</p> <p>Findings include: Clients #1, #2, and #3 were observed at</p>	W 0473	<p>client 2 knows that it is in his best interest to practice the evacuation, in the case of emergency, and has been cooperative. To ensure this deficient practice does not re-occur, the QDDP and/or group home director will review all fire drills and investigate issues that are noted. Documentation and follow-up notes will be attached to the fire drill record.</p> <p>This deficient practice affected all clients, in this group home. To correct this, the agency has retained all group home staff on the appropriate servicing of hot and cold food. To ensure this deficient practice does not reoccur, the group home director and or</p>	06/17/2016

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	<p>the group home during the 5/25/16 observation period from 5:44 A.M. until 7:15 A.M. Upon entering the group home at 5:44 A.M., a cooked biscuit, gravy, and cheese casserole was on the counter in the kitchen. Client #6 served the casserole to clients #1 and #3 at 6:16 A.M. Direct care staff served the casserole to client #2 at 7:03 A.M. The casserole was not kept warm during the observation period.</p> <p>Director of Residential Services #1 was interviewed on 5/26/16 at 9:22 A.M. Director of Residential Services #1 stated, "Foods should be kept warm or cold until they (clients) eat."</p> <p>9-3-8(a)</p>		<p>QDDP or group home manager will conduct daily quality assurance visits, to ensure that food is being served at the appropriate temperature and at the appropriate time. After 10 successful daily checks, the QDDP will access the need for continued monitoring. If continued monitored is not needed, the QDDP will monitor through monthly checks, and maintain that documentation.</p>		