

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G511	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/28/2016
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NAME OF PROVIDER OR SUPPLIER OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5949 FIESTA AVE PORTAGE, IN 46368
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W 0000 Bldg. 00	<p>This visit was for a recertification and state licensure survey.</p> <p>Dates of Survey: 4/21, 4/22, 4/25, 4/26 and 4/28/16.</p> <p>Facility number: 001025 Provider number: 15G511 AIM number: 100245170</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 5/5/16.</p>	W 0000		
W 0154 Bldg. 00	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on interview and record review for 3 of 13 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to conduct a thorough investigation in regard to the allegations of abuse, neglect and/or injuries of unknown injuries for clients #3, #5 and #6.</p> <p>Findings include:</p> <p>1. The facility's reportable incident</p>	W 0154	To identify clients that may have been affected by this deficient practice, an audit has been completed all incident reports of injuries of unknown origin. The audit found that no other clients, in this group home, were affected by this deficient practice. As part of a systematic change and policy change, the agency now investigates all incidents of injuries of unknown origin, regardless of severity. To assist and formalize investigations, a standardized form(see attached)	05/16/2016

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>reports, internal Generated Event Reports and/or investigations were reviewed on 4/21/16 at 1:41 PM. The facility's 12/9/15 reportable incident report indicated on 12/8/15, "It was reported by staff that when she came on her shift and did a bed check that [client #6] had dried feces on his buttocks, penis and undergarment. Upon notification of the allegation, staff were immediately suspended and did not have any client contact for the duration of the investigation. Due to the details of the investigation the allegation has been unsubstantiated...."</p> <p>The facility's 12/9/15 Report of Investigation Final Report indicated staff #4 was suspended during the allegation of neglect investigation. The facility's investigation indicated "[Staff #3] reported that when she arrived for her shift she started doing bed checks. [Staff #3] stated that when she checked [client #6] he had feces on his hands, stomach and face. [Staff #3] said she took him to the bathroom and got him in the shower. [Staff #3] states that she thinks he was in the undergarments that he had on at day services because there were initials on it. [Staff #3] reported that he had dried feces on his buttocks, penis area and inside the undergarment."</p>		<p>has been developed and implemented, as of 3.7.16. To further identify other clients that may have been affected by this deficient practice, the facility looked at all other investigations of abuse and neglect for this group home and found that no other clients were affected by this deficient practice. As part of a procedure change, the agency now investigates and/or interviews all applicable employees working in the group home and then determines a recommendation for all incidents of abuse or neglect. To ensure interviews and a determination are completed, the Social Services Director will review every report of abuse or neglect, signing off on all complete reports.</p>				

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	<p>The facility's 12/9/15 investigation indicated 2 facility staff were working with the client prior to staff #3's coming in to work. The facility's investigation indicated staff #4 indicated client #6 had been checked when the client arrived home from the day service program. The facility's investigation indicated staff #4 stated she had checked client #6's undergarments after 6:30 PM and client #6 "...was still clean and dry. [Staff #4] reports that undergarments are checked at least every two hours or if an odor is present. [Staff #4] said that they do not document checks only if they had a bowel movement or if [client #6] urinates that is documented. [Staff #4] reported that [client #6] was checked right before bed, around 7:30 and he was still clean and dry. [Staff #4] stated that [client #6] needs to be showered usually when he has a bowel movement."</p> <p>The facility's 12/9/15 investigation indicated staff #5 worked and was a relief staff. The investigation indicated staff #5 did not check and/or change client #6. The facility's investigation indicated "... [Staff #5] stated that she thinks that undergarments are supposed to be changed when they arrive home from the day services." The facility's 12/9/15 indicated "Recommendations: unsubstantiated." The facility's 12/9/15</p>			

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	<p>investigation did not indicate the day service program staff were interviewed to see when client #6 was last changed and/or interview any other additional staff who worked with the client to learn of the client's bowel habits/patterns, and/or if the client had been found in the same condition before. The facility's investigation did not include any recommendations and/or retraining of staff in regard to documentation/checking clients every 2 hours.</p> <p>Interview with the Quality Assurance (QA) Coordinator via email on 4/25/16 at 1:34 PM indicated "The recommendation was the allegation was unsubstantiated, but no other recommendations were noted. I (QA Coordinator) spoke with the staff that were on the shift and also the assistant manager about this incident."</p> <p>2. The facility's reportable incident reports, internal GERs and/or investigations were reviewed on 4/21/16 at 1:41 PM. The facility's reportable incident reports, GERs and/or investigations indicated the following (not all inclusive):</p> <p>-2/19/16 "...staff found bruises on [client #3's] right thigh and left thigh. Staff</p>			

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	<p>stated, '[client #3] has four 1 cm (centimeter) circular bruises and four 1/2 cm circular bruises in her inner right thigh. She also has 1 cm circular bruise on her inner left thigh. Bruises are purple in color.' [Client #3] usually bruises easily and the pea size bruises could have come from her place (sic) something on her thighs such as books, toys, or her teddy bear. Staff will continue to monitor [client #3] placing items on her thighs to prevent bruises...." The 2/19/16 reportable incident report did not indicate anyone was interviewed in regard to client #3's injury of unknown source and/or indicate any documentation of an investigation other than the assumption/summation of client #3's bruises.</p> <p>-10/31/15 "...[Client #5] has a bruise (sic) left hip/stomach. Staff stated they did not notice the bruise the night before. Staff also stated the bruise is 3 inches long and 1/2 inch long. QDDP (Qualified Developmental Disabilities Professional) asked staff to check her gait belt to see if that could have caused the bruise and due to how loose the gait belt is. QDDP also asked staff to check [client #5's] pants to see if that could have caused the bruise. Staff stated her pants are loose due to her weight loss. QDDP will continue to look at environmental factors that could cause</p>			

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W 0157 Bldg. 00	<p>this bruise...The IDT will continue to monitor the health and safety of [client #5]." The 10/31/15 reportable incident report did not include documentation of an investigation and/or indicate who was interviewed in regard to the client's bruise.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 4/26/16 at 11:30 AM indicated she would check to see if an investigation had been conducted and/or documented on a follow-up report. No additional documentation was provided for client #3's and #5's injuries of unknown source.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on interview and record review for 1 of 3 allegations of neglect and/or abuse reviewed, the facility failed to recommend and/or put in place any corrective actions/measures to ensure client #6 was toileted every 2 hours.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, internal Generated Event Reports and/or</p>	W 0157	To identify other clients that may have been affected by this deficient practice, the facility looked at all other investigations of abuse and neglect for this group home and found that no other clients were affected by this deficient practice. As part of a procedure change, the agency now investigates and determines a recommendation for all incidents of abuse or neglect. To ensure a determination is made on every report, the Social	05/16/2016			

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	<p>investigations were reviewed on 4/21/16 at 1:41 PM. The facility's 12/9/15 reportable incident report indicated on 12/8/15, "It was reported by staff that when she came on her shift and did a bed check that [client #6] had dried feces on his buttocks, penis and undergarment. Upon notification of the allegation, staff were immediately suspended and did not have any client contact for the duration of the investigation. Due to the details of the investigation the allegation has been unsubstantiated...."</p> <p>The facility's 12/9/15 Report of Investigation Final Report indicated staff #4 was suspended during the allegation of neglect investigation. The facility's investigation indicated "[Staff #3] reported that when she arrived for her shift she started doing bed checks. [Staff #3] stated that when she checked [client #6] he had feces on his hands, stomach and face. [Staff #3] said she took him to the bathroom and got him in the shower. [Staff #3] states that she thinks he was in the undergarments that he had on at day services because there were initials on it. [Staff #3] reported that he had dried feces on his buttocks, penis area and inside the undergarment."</p> <p>The facility's 12/9/15 investigation indicated 2 facility staff were working</p>		<p>Services Director will review and sign off on every report of abuse or neglect. To further ensure that documentation is maintained, of proper 2-hour toileting, the agency now documents all toileting through Therap Software. To ensure documentation is accurate and thorough, the QDDP and or Group Home Director will review toileting documentation, daily, for two consecutive weeks. After the two week examination, the QDDP and Director will determine if the audits need to continue or cease.</p>		

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	<p>with the client prior to staff #3's coming in to work. The facility's investigation indicated staff #4 indicated client #6 had been checked when the client arrived home from the day service program. The facility's investigation indicated staff #4 she had checked client #6's undergarments after 6:30 PM and client #6 "...was still clean and dry. [Staff #4] reports that undergarments are checked at least every two hours or if an odor is present. [Staff #4] said that they do not document checks only if they had a bowel movement or if [client #6] urinates that is documented. [Staff #4] reported that [client #6] was checked right before bed, around 7:30 and he was still clean and dry. [Staff #4] stated that [client #6] needs to be showered usually when he has a bowel movement."</p> <p>The facility's 12/9/15 investigation indicated staff #5 worked and was a relief staff. The investigation indicated staff #5 did not check and/or change client #6. The facility's investigation indicated "... [Staff #5] stated that she thinks that undergarments are supposed to be changed when they arrive home from the day services." The facility's 12/9/15 indicated "Recommendations: unsubstantiated." The facility's investigation did not include any corrective actions in regard to retraining</p>			

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W 0295 Bldg. 00	<p>staff in regard to documentation/checking clients every 2 hours.</p> <p>Interview with the Quality Assurance (QA) Coordinator via email on 4/26/16 at 1:34 PM indicated "The recommendation was the allegation was unsubstantiated, but no other recommendations were noted."</p> <p>9-3-2(a)</p> <p>483.450(d)(1)(i) PHYSICAL RESTRAINTS</p> <p>The facility may employ physical restraint only as an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied.</p> <p>Based on interview and record for 2 of 2 sampled clients (#1 and #2), who had restraints in their Behavior Support Plans (BSPs), the facility failed to indicate the specific restraint(s) which could be utilized with the clients when they demonstrated physical aggression toward others and/or self-injurious behavior.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 4/25/16 at 12:12 PM. Client #1's 8/25/15 BSP indicated client #1 demonstrated the</p>	W 0295	A file audit has been conducted, to ensure that no other clients have been affected by this deficient practice; findings conclude that no other clients were affected. The behavior support plan, for client #1 and #2, has been amended to include specified CPI physical restraints. To ensure this deficient practice does not reoccur, the QDDP is now tasked with ensuring that every client's behavior support plan, with approved CPI physical restraints, including the specifiedCPI approved restraint. To ensure this process is	05/30/2016

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	<p>behaviors of physical aggression defined as "Any behavior intended to harm another person, such as hitting, kicking, pushing, biting, pinching, spitting in staffs face, attacking others when staffs backs are turned or facing [client #1] or attempts to do so." Client #1's BSP indicated "...If at any point physical aggression escalates to the point that [client #1] is a risk to himself or others, the least restrictive but most effective procedures of physical restraint should be used...." Client #1's BSP did not specifically indicate the type of physical restraint(s) which could be utilized with the client when he demonstrated physical aggression.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) and administrative staff #1 on 4/26/16 at 11:30 AM indicated client #1's BSP did not indicate the type of restraint which could be utilized with the client.</p> <p>2. Client #2's record was reviewed on 4/25/16 at 2:12 PM. Client #2's 4/27/15 BSP indicated client #2 demonstrated physical aggression, property destruction, food stealing elopement and self-injurious behavior. Client #2's BSP indicated "...If any point [client #2's] behaviors (physical aggression or self-injurious behavior) increase in</p>		<p>implemented correctly, a quality assurance audit, of client records, will occur monthly, by the GroupHome Director or designee. The audit will examine all client records and seek to find that each client, who has a behavior support plan with physical restraints, has a plan that specifies the CPI physical restraint(s) to be utilized.</p>		

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W 0312 Bldg. 00	<p>intensity or frequency and he is at risk of causing injury to himself or others, the least restrictive but most effective physical restraint as trained by the facility should be implemented....." Client #2's 4/27/15 BSP did not specify and/or indicate the type of physical restraint(s) which could be utilized with the client when he his behaviors intensified.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) and administrative staff #1 on 4/26/16 at 11:30 AM indicated client #2's BSP did not indicate the type of restraint which could be utilized with the client.</p> <p>9-3-5(a)</p> <p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on interview and record review for 1 of 2 sampled clients (#1) on behavior controlling medications, the facility failed to ensure a medication to treat the client's anxiety was part of the client's behavior plan.</p> <p>Findings include:</p>	W 0312	Client (#1) has a behavior support plan that failed to ensure the accurate list of the client's current medications. On 4.28.16, the QDDP updated the client's behavior support plan, to include his currently prescribed of Hydroxyzine. The plan now also includes a medication reductions plan, for this medication. To	05/16/2016

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	<p>Client #1's record was reviewed on 4/25/16 at 12:12 PM. Client #1's April 2016 physician's orders indicated client #1 received Hydroxyzine 50 milligrams 1 capsule two times a day for anxiety.</p> <p>Client #1's 8/25/15 Behavior Support Plan (BSP) indicated client #1 could exhibit "extreme anxiety" defined as "stomping his feet, running, spitting on the floor, running or walking into walls, flicking his nose several times with one or two fingers, shaking his hands vigorously and jumping up and down in place." Client #1's BSP did not indicate the client's Hydroxyzine which was being to treat the client's anxiety was part of the client's BSP. Client #1's BSP also did not include a plan of reduction to reduce the behaviors for which the Hydroxyzine was prescribed.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 4/26/16 at 11:30 AM indicated she forgot to add the Hydroxyzine to client #1's BSP when it was prescribed over a year ago.</p> <p>9-3-5(a)</p>		<p>ensure this deficient practices not affected other clients, the QDDP(s) and Group Home Director audited client files, with behavior support plans; no other clients were found to have been affected by this practice. To ensure this deficient practice does not re-occur, the QDDP will review the client's BSP, monthly, with the GroupHome Registered Nurse, to ensure the accuracy of the medications listed;documentation of reviews will be housed in the QDDP's monthly IDT notes.</p>		