

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G044	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/12/2013
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NAME OF PROVIDER OR SUPPLIER OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6381 LUTE RD PORTAGE, IN 46368
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: March 18, 19 and April 3, 11 and 12, 2013.</p> <p>Facility number: 000600 Provider number: 15G044 AIM number: 100233500</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 April 19, 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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W000192	<p>483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>Based on record review and interview, the facility failed for 2 of 4 sampled clients (client #1 and #4) by staff not demonstrating skills and competency to order and administer medications as prescribed.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services and internal incident/accident reports was conducted on 3/18/13 at 12:30 P.M. Review of the reports indicated:</p> <p>Client #1 incident report dated 4/3/12: "Upon passing 7 A.M. medications, I noticed on bubble pack of Florastor 250 mg (milligram) (probiotic), it was written that this medication was to be given every other day. This medication is given daily. It is Omeprazole (for stomach acid) that is given every other day, per doctor. Result being is that [client #1] did not receive his Florastor yesterday."</p> <p>Client #4 incident dated 12/18/12: [Client #4]'s hydrocerin creme (moisturizer) was reordered the morning</p>	W000192	<p>W192-QDDP-D will retrain staff on policy 5210, this policy includes how to properly order medications and when to notify nursing when refills are needed. Policy 5105 will also be reviewed which includes the 6 rights of medication administration. The 6 rights include "Give the right dose-check order with label". To ensure further compliance, the group home managers will monitor medication supplies weekly to ensure the proper amount of medication is available. In addition, staff will participate in the Med Review Training annually to ensure the six rights of medication administration are reviewed, including how to properly order medications in a timely manner.</p>	05/03/2013	

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	<p>of 12/16/12 however the pharmacy was unable to fill it at that time. At 8:00 P.M. that evening the last of it was used. At 7:00 A.M. on 12/17/12 the hydrocerin creme was not applied due to being unavailable the med (medication) passer informed the Group Home Manager (GHM). I saw the med error and contacted the QDDP (Qualified Developmental Disabilities Professional) to ask if she had been contacted in regards to this she said no. She said that she would contact the nurse in regards to this I was informed to fill out a medication error incident report."</p> <p>An interview with the Qualified Intellectual Disabilities Professional Designee (QIDPD) was conducted on 4/11/13 at 2:30 P.M. The QIDPD indicated staff are trained to make sure there is at least a 5 day supply for all clients medications available at all times at the group home. The QIDPD further indicated medications should be administered as ordered.</p> <p>9-3-3(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, the facility failed 4 of 4 sampled clients (clients #1, #2, #3, #4), and 1 additional client (client #5), to implement written objectives/training during times of formal/informal training opportunities.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 3/19/13 from 6:15 A.M. until 8:00 AM. During the observation period clients #1, #2, #3 and #4 were sitting in the living room unsupervised and with no activity. Client #5 sat asleep in a recliner during the entire observation. Direct Support Professional (DSP) #1 assisted client #5 with morning hygiene and assisted in meal preparation and DSP #2 administered medications while clients #1, #2, #3, #4 and #5 sat unsupervised and with no activity. There was no choice of activities offered nor implementation of clients' goals during this observation</p>	W000249	<p>W249-The QDDP-D will retrain staff to ensure implementation of IPP goals are being completed properly. The QDDP-D will inform staff that goals should be implemented formally/informally at all times of opportunity. To ensure further compliance, The QDDP-D will monitor on a monthly basis through completed data and monthly observations at the home. The Lead Manger will also monitor at their monthly home visits. GH Manager will monitor on an ongoing basis to ensure choice activities are offered and client's goals are being implemented consistently.</p>	05/03/2013			

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	<p>period.</p> <p>An evening observation was conducted at the group home on 3/20/13 from 3:45 P.M. until 6:00 P.M. From 3:45 P.M. until 4:30 P.M., DSP #3 was the only staff present and working with all clients at the group home. DSP #3 worked in the kitchen preparing dinner while clients #1, #2 and #3 sat in the living room with no activity. Client #4 lay in his room with no activity.</p> <p>A review of client #1's record was conducted on 4/3/13 at 3:30 P.M. The Individual Program Plan (IPP) dated 12/12/12 indicated: "Will put items in their designated area...Will write a letter to someone...Will measure dry/liquid ingredients...will complete an activity with a peer for at least 20 minutes...will clean his eye glasses."</p> <p>A review of client #2's record was conducted on 4/3/13 at 3:55 P.M. A review of client #2's ISP (Individual Support Plan) dated 11/2/12 indicated: "Will greet staff...will put his clean clothes away...will take his dirty laundry and place it in the proper laundry basket...will open one package of vegetables at dinner."</p> <p>A review of client #3's record was</p>			

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	<p>conducted on 4/3/13 at 4:25 P.M. The ISP dated 11/19/12 indicated: "Will write name two times a day...continue to improve and increase attention span through use of verbal prompts and engaging him in desirable activities...continue computer goal and working on attention span...will sit at table and work on an activity."</p> <p>A review of client #4's record was conducted on 4/3/13 at 4:50 P.M. The ISP dated 6/27/12 indicated: "Will write mock checks...will learn to tie his shoes...will exercise for 10 minutes...will turn the stove on to the proper level of heat...will state 3 side effects of his medicine."</p> <p>A review of client #5's record was conducted on 4/3/13 at 5:15 P.M. The ISP dated 1/21/13 indicated: "Will state the name and point to the correct dollar amount...will exercise for 10 minutes...will hang clothes up...will clean headphones...will say hello."</p> <p>The Qualified Intellectual Disabilities Professional Designee (QIDPD) was interviewed on 4/11/13 at 2:30 P.M. The QIDPD indicated active treatment should be ongoing and training objectives should be implemented at all times of opportunity.</p>				

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W000383	<p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area. Based on observation and interview, the facility failed for 8 of 8 clients residing at the group home (clients #1, #2, #3, #4, #5, #6, #7 and #8), to ensure only authorized persons had access to the keys to the medication room and medication cart.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 3/18/13 from 6:00 A.M. until 7:45 A.M. During the entire observation period clients #1, #2, #3, #4, #5, #6, #7 and #8 walked up and down the hallway passing by the medication room. At 6:35 A.M., Direct Support Professional (DSP) #2 began administering client #8's prescribed medications. At 6:45 A.M., DSP #2 placed the medication keys on top of the medication cart, left it unattended in the medication room, entered the kitchen and began talking to DSP #1. At 7:05 A.M., DSP #2 entered the unsecured medication office, picked the keys up from the medication cart, unlocked the medication cart and began passing client #4's prescribed medications. After administering client #4's prescribed medications, DSP #2 placed the keys to</p>	W000383	W383-QDDP-D will retrain staff on the procedure for proper locking of the medication cart and not leaving the med key unattended. To ensure further compliance, the QDDP-D, Lead Manager and GH Nurse will monitor on an ongoing basis at monthly and random home visits.	05/03/2013			

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	<p>the medication room/cart back on top of the medication cart and exited the unsecured medication room and entered the living room. At 7:15 A.M., DSP #2 entered the unsecured medication office picked up the medication keys from the medication cart, unlocked the medication cart and began passing client #7's prescribed medications. After administering client #7's medications, DSP #2 placed the medication room/cart keys on top of the medication cart and exited the unsecured office and entered the kitchen area.</p> <p>An interview with the Qualified Intellectual Disabilities Professional Designee (QIDPD) was conducted on 4/11/13 at 2:30 P.M. The QIDPD indicated the keys should only be available to authorized persons and further indicated the person responsible for administering medications should have the keys on them at all times.</p> <p>9-3-6(a)</p>			