

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G512	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/24/2014
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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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W000000	<p>This visit was for the investigation of complaint #IN00157580.</p> <p>COMPLAINT #IN00157580: SUBSTANTIATED, Federal and state deficiencies related to the allegation(s) are cited at W104, W149 and W154.</p> <p>Unrelated deficiencies cited.</p> <p>Dates of Survey: November 14, 17, 18, 20 and 24, 2014.</p> <p>Facility number: 001026 Provider number: 15G512 AIM number: 100245160</p> <p>Surveyor: Christine Colon, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/10/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	483.410(a)(1)			

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>GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview for 1 of 3 sampled clients and 1 additional client (clients A and F), the governing body failed to ensure the facility's Qualified Intellectual Disabilities Professionals (QIDP) and Inter Disciplinary Team (IDT) were informed and participated in the investigation process.</p> <p>Findings include:</p> <p>A request for the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Incident reports and investigations was made on 11/14/14 at 1:00 P.M.. The Qualified Intellectual Disabilities Professional (QIDP) informed this surveyor that the investigation records would have to be retrieved from the investigator because she did not have access to the investigation records.</p> <p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Incident reports and investigations was conducted on 11/14/14 at 7:00 P.M. and indicated:</p> <p>-Investigation dated 9/22/14 involving</p>	W000104	<p>TheQDDP will be retrained on agency policy, regarding investigations of suspected or alleged reports of abuse and neglect. Agency policy allows for communication, with the IDT team, about alleged abuse and neglect incident outcomes, at the discretion of agency administration. Agency policy (see attached) deems that after an investigation is concluded, the Day Service Senior Director or Vice President of Consumer Services will discuss recommendations with the appropriate Director and Human Resources Director to determine what action is to be taken, including but not limited to retraining, corrective action, suspension or termination. Further, agency policy states that the Social Services Senior Director or designee will follow up with the consumer regarding the incident outcomes and a team meeting will be convened if necessary.</p>	12/29/2014

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	<p>client F and staff #22 indicated: "[Client F] reported to staff that his midnight staff 'treats him like garbage.'"</p> <p>-Investigation record dated 10/5/14 involving client A and staff #22 indicated: "It was reported that [client A]'s bedding was saturated with urine and his mattress was also wet...When I started taking things off, I realized that layer after layer of everything on the bed was dripping of urine, and not just the top pad like I had assumed. His top pad, fitted sheet, another pad, mattress protector and bed underneath were all soaked in urine." Review of the investigation failed to indicate staff #22 toileted client A every 2 hours.</p> <p>An interview with QIDP #2 was conducted on 11/17/14 at 11:15 A.M.. When asked for the BDDS reports in regards to the mentioned investigated incidents, QIDP #2 indicated she was not aware of the incidents. When asked about the outcome of the investigation, QIDP #2 indicated the facility's QIDPs do not have privileged information in regard to allegations of abuse and neglect of clients. When asked how the facility reports incidents and then investigates, QIDP #2 indicated staff document an IR if the incident is potentially an allegation of abuse or neglect, then the staff</p>			

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	<p>forwards it directly to the investigator, who then submits a BDDS report. The QIDP stated the QIDPs are "never made aware" of the incident or the investigation. The QIDP indicated the investigator conducts the investigation and makes any recommendations and decides what actions are to be taken. When asked if the investigator is part of the facility's IDT, QIDP #2 indicated they were not. When asked if the facility's IDT discusses and addresses the incidents, QIDP #2 indicated they did not. QIDP #2 indicated the QIDPs and IDT do not have access to the BDDS reports or investigation records.</p> <p>An interview with the investigator was conducted on 11/20/14 at 12:30 P.M.. The investigator indicated the facility trains staff to document incidents of abuse/neglect on IR and then forward the reports to the investigator. The investigator indicated once the investigators receive IRs, the investigator is responsible for submitting the report to BDDS. The investigator indicated investigations are immediately started. The investigator makes the determination based on their findings and then decides if the staff is to be terminated or requires retraining and whatever disciplinary actions should be taken. When asked if the IDT is made aware of the incidents of</p>			

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	<p>abuse/neglect, the investigator indicated they are not. The investigator indicated just the person involved in the incident is interviewed. The investigator indicated the QIDPs and IDT are not involved in the reporting to BDDS, investigation and not involved in the corrective/disciplinary action. The investigator indicated no information is given to the IDT to address the incident.</p> <p>This federal tag relates to complaint #IN00157580.</p> <p>9-3-1(a)</p>				
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 2 of 3 sampled clients and 1 additional client (clients A, C, and F), the facility failed to implement written policy and procedures in regards to preventing staff neglect and conducting thorough investigations of injuries of unknown origin.</p>	W000149	<p>Staff will be retrained on conducting thorough investigations of injuries of unknown origin. To ensure a thorough investigation, the QDDP will immediately be trained on and required to attach an "Investigative Report Form" (see attached form) to each investigation regarding an injury of unknown origin. All group</p>	12/29/2014	

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	<p>Findings include:</p> <p>1. A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Incident reports and investigations was conducted on 11/14/14 at 7:00 P.M. and indicated:</p> <p>-Investigation dated 9/22/14 involving client F and staff #22 indicated: "[Client F] reported to staff that his midnight staff 'treats him like garbage.'" Further review of the investigation failed to indicate all staff who worked at the group home were interviewed.</p> <p>-Investigation record dated 10/5/14 involving client A and staff #22 indicated: "It was reported that [client A]'s bedding was saturated with urine and his mattress was also wet...When I started taking things off, I realized that layer after layer of everything on the bed was dripping of urine, and not just the top pad like I had assumed. His top pad, fitted sheet, another pad, mattress protector and bed underneath were all soaked in urine." Review of the investigation failed to indicate staff #22 toileted client A every 2 hours. Further review of the record failed to indicate the staff who was reported the incident and all staff who worked at the group home were</p>		<p>home staff were retrained, on 12.19.14, on the proper procedure for documenting body checks, bed checks, and two hour toileting. All documentation for body checks, bed checks, and two hour toileting is secured within the agency's new software program, <i>Therap Services</i>. The agency will continue to ensure participants are not subjected to client to client aggression. After the first incident, dated 8.8.14, the participants were separated, so that their proximity was not close to each other; however, they both still worked in the same line. After these second and third report, dated 8.22.14 & 8.26.14, the QDDP worked with the Director of that day service department to completely rearrange the work lines, therefore separating the clients. As a result, there have not been any further reports of client to client aggression.</p>				

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	<p>interviewed.</p> <p>An interview with the investigator was conducted on 11/20/14 at 12:30 P.M.. The investigator indicated staff at the group home are trained upon working at the group home to document bed checks, body checks, two hour toileting documentation. The investigation indicated staff at the group home were not properly documenting bed checks, body checks and two hour toileting. When asked if all staff who worked at the group home were interviewed, the investigator indicated they were not.</p> <p>2. A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Incident reports and investigations was conducted on 11/14/14 at 1:00 P.M. and indicated:</p> <p>-IR dated 8/15/14 involving client F indicated: "[Client F] requested PC (Personal Care). I radioed [PC #11] and [PC #12] responded by radio that they were both busy and it would be a couple of minutes. Less than 15 minutes later, [PC #12] approached [client F] and began to explain to him that he needed to stop calling for PC right after his lunch. She also told him that participants only had so many times a day that they were allowed to have PC to use the bathroom.</p>				

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	<p>She also made comments about [Facility] financials pertaining to [Facility] being able to bill out only so many times a day for certain participant's PC care. She made the comment more than once, that he wasn't the only one needing PC and that there were other participants waiting to go to the bathroom. She then informed him that he would still have to wait to be cleaned. It took another 20 minutes for PC to come assist. After [PC #12] left the area, after speaking with [client F]), I approached [client F] and apologized on behalf of [Facility] on how he was spoken to. I explained to him that [Facility]'s first priority was his well being. I asked him if he understood, he said 'Yes' then [client F] said to me 'thank you.'" Further review of the report failed to indicate an investigation was conducted in regard to this allegation of neglect.</p> <p>-IR dated 8/26/14 involving client F indicated: "Participants personal care staff reported a discolored area that was sore to touch on [client F]'s right lower buttock. Examined area red to purple 2" (inch) long by 1" bruise positioned over bony area low on right buttock." Further review of this report failed to indicate an investigation was conducted in regard to this injury of unknown origin.</p>			

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	<p>-BDDS report dated 10/1/14...Date of Knowledge: 10/9/14...Submitted Date: 10/11/14 involving client C indicated: "On 10/9/14, [Nurse] informed [Qualified Developmental Disabilities Professional (QDDP)] of a scrape on participant's right knee, approximately 1.5 inches long by 1 inch wide. [Nurse] explained to QDDP that [Staff #20] had notified her of the scrape. [Nurse] explained that [Staff #20] explained that during personal care, [Staff #20] discovered the scrape. The injury was covered by a dry gauze pad taped over it. [Nurse] went and examined the injury, she removed the gauze, which caused some of the scab to peel off which caused minor bleeding. [Nurse] then cleaned the area, applied triple antibiotic ointment to the scrape and covered it with a large adhesive Band-Aid. Upon review of the GH (Group Home) notes, not listed in [Computer System], it was noted that GH staff discovered the scrape on 10/1/14 and administered first aid; cleaned the area and applied triple antibiotic ointment and bandage. Neither nursing nor QDDP was informed of injury until the 10/9/14 discovery." Further review of the record failed to indicate an investigation was conducted in regard to the injury of unknown origin.</p> <p>An interview with the Qualified</p>			

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	<p>Intellectual Disabilities Professional (QIDP) was conducted on 11/24/14 at 12:20 P.M.. When asked if there was written documentation to indicate thorough investigations were completed in regards to the incidents of injuries of unknown origin, the QIDP indicated there was no documentation.</p> <p>A review of the facility's policy titled, "Universal Policies and Procedures, Adult Services, Policy #: 6012 - Abuse and Neglect" dated 8/8/13, was conducted on 11/17/14 at 7:30 P.M. and indicated, "...does not condone and will not tolerate physical, verbal or sexual abuse, neglect or exploitation of individuals served." Abuse was defined as "The willful infliction of pain or injury, unnecessary physical or chemical 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</p>			

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	<p>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 Services within 5 working days following the report of the incident."</p> <p>This federal tag relates to complaint #IN00157580.</p> <p>9-3-2(a)</p>			

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W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview, the facility failed for 1 of 3 sampled clients (client C), to report an allegation of suspected abuse/neglect immediately to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Incident reports and investigations was conducted on 11/14/14 at 1:00 P.M. and indicated:</p> <p>-BDDS report dated 10/1/14...Date of Knowledge: 10/9/14...Submitted Date: 10/11/14 involving client C indicated: "On 10/9/14, [Nurse] informed [Qualified Developmental Disabilities Professional (QDDP)] of a scrape on participant's right knee, approximately 1.5 inches long by 1 inch wide. [Nurse] explained to QDDP that [Staff #20] had notified her of the scrape. [Nurse]</p>	W000153	QDDP will be retrained on conducting thorough investigations of injuries of unknown origin and the procedure for submitted BDDS reports, within the 24 hour timeframe. To ensure a thorough investigation, the QDDP will immediately be trained on and required to attach an "Investigative Report Form" (see attached form) to each investigation regarding an injury of unknown origin.	12/29/2014
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	<p>explained that [Staff #20] explained that during personal care, [Staff #20] discovered the scrape. The injury was covered by a dry gauze pad taped over it. [Nurse] went and examined the injury, she removed the gauze, which caused some of the scab to peel off which caused minor bleeding. [Nurse] then cleaned the area, applied triple antibiotic ointment to the scrape and covered it with a large adhesive Band-Aid. Upon review of the GH (Group Home) notes, not listed in [Computer System], it was noted that GH staff discovered the scrape on 10/1/14 and administered first aid; cleaned the area and applied triple antibiotic ointment and bandage. Neither nursing nor QDDP was informed of injury until the 10/9/14 discovery." Further review of the report failed to indicate this injury of unknown origin was reported to immediately to the administrator and to BDDS in a timely manner.</p> <p>The Qualified Intellectual Disabilities Professional (QIDP) was interviewed on 11/24/14 at 12:20 P.M.. The QIDP indicated this injury of unknown origin was not immediately reported to the administrator or BDDS. The QIDP further indicated the injury of unknown origin should have been immediately reported to the administrator and within 24 hours to BDDS.</p>			

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W000154	<p>9-3-2(a)</p> <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 3 sampled clients and 1 additional client (clients A, C and F), the facility failed to provide written evidence thorough investigations were conducted in regard to allegations of staff neglect and injuries of unknown origin.</p> <p>Findings include:</p> <p>1. A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Incident reports and investigations was conducted on 11/14/14 at 7:00 P.M. and indicated:</p> <p>-Investigation dated 9/22/14 involving client F and staff #22 indicated: "[Client F] reported to staff that his midnight staff 'treats him like garbage.'" Further review of the investigation failed to indicate all</p>	W000154	The agency will ensure, regarding investigations of abuse or neglect, that all staff, who are reasonably thought to have information or direct knowledge of the alleged or suspected incident, are interviewed as a part of the investigation. QDDP will be retrained on conducting thorough investigations of injuries of unknown origin. To ensure a thorough investigation, the QDDP will immediately be trained on and required to attach an "Investigative Report Form" (see attached form) to each investigation regarding an injury of unknown origin.	12/29/2014

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	<p>staff who worked at the group home were interviewed.</p> <p>-Investigation record dated 10/5/14 involving client A and staff #22 indicated: "It was reported that [client A]'s bedding was saturated with urine and his mattress was also wet...When I started taking things off, I realized that layer after layer of everything on the bed was dripping of urine, and not just the top pad like I had assumed. His top pad, fitted sheet, another pad, mattress protector and bed underneath were all soaked in urine." Review of the investigation failed to indicate staff #22 toileted client A every 2 hours. Further review of the investigation failed to indicate the staff who was reported the incident and all staff who worked at the group home were interviewed.</p> <p>An interview with the investigator was conducted on 11/20/14 at 12:30 P.M.. The investigator indicated staff at the group home are trained upon working at the group home to document bed checks, body checks, two hour toileting documentation. The investigation indicated staff at the group home were not properly documenting bed checks, body checks and two hour toileting. When asked if all staff who worked at the group home were interviewed, the</p>						

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	<p>investigator indicated they were not.</p> <p>2. A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Incident reports and investigations was conducted on 11/14/14 at 1:00 P.M. and indicated:</p> <p>-IR dated 8/15/14 involving client F indicated: "[Client F] requested PC (Personal Care). I radioed [PC #11] and [PC #12] responded by radio that they were both busy and it would be a couple of minutes. Less than 15 minutes later, [PC #12] approached [client F] and began to explain to him that he needed to stop calling for PC right after his lunch. She also told him that participants only had so many times a day that they were allowed to have PC to use the bathroom. She also made comments about [Facility] financials pertaining to [Facility] being able to bill out only so many times a day for certain participant's PC care. She made the comment more than once, that he wasn't the only one needing PC and that there were other participants waiting to go to the bathroom. She then informed him that he would still have to wait to be cleaned. It took another 20 minutes for PC to come assist. After [PC #12] left the area, after speaking with [client F]), I approached [client F] and apologized on behalf of [Facility] on how he was</p>			
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	<p>spoken to. I explained to him that [Facility]'s first priority was his well being. I asked him if he understood, he said 'Yes' then [client F] said to me 'thank you.'" Further review of the report failed to indicate an investigation was conducted in regard to this allegation of neglect.</p> <p>-IR dated 8/26/14 involving client F indicated: "Participants personal care staff reported a discolored area that was sore to touch on [client F]'s right lower buttock. Examined area red to purple 2" (inch) long by 1" bruise positioned over bony area low on right buttock." Further review of this report failed to indicate an investigation was conducted in regard to this injury of unknown origin.</p> <p>-BDDS report dated 10/1/14...Date of Knowledge: 10/9/14...Submitted Date: 10/11/14 involving client C indicated: "On 10/9/14, [Nurse] informed [Qualified Developmental Disabilities Professional (QDDP)] of a scrape on participant's right knee, approximately 1.5 inches long by 1 inch wide. [Nurse] explained to QDDP that [Staff #20] had notified her of the scrape. [Nurse] explained that [Staff #20] explained that during personal care, [Staff #20] discovered the scrape. The injury was covered by a dry gauze pad taped over it.</p>			

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	<p>[Nurse] went and examined the injury, she removed the gauze, which caused some of the scab to peel off which caused minor bleeding. [Nurse] then cleaned the area, applied triple antibiotic ointment to the scrape and covered it with a large adhesive Band-Aid. Upon review of the GH (Group Home) notes, not listed in [Computer System], it was noted that GH staff discovered the scrape on 10/1/14 and administered first aid; cleaned the area and applied triple antibiotic ointment and bandage. Neither nursing nor QDDP was informed of injury until the 10/9/14 discovery." Further review of the record failed to indicate an investigation was conducted in regard to the injury of unknown origin.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 11/24/14 at 12:20 P.M.. When asked if there was written documentation to indicate thorough investigations were completed in regards to the incidents of injuries of unknown origin, the QIDP indicated there was no documentation.</p> <p>This federal tag relates to complaint #IN00157580.</p> <p>9-3-2(a)</p>				

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W009999	<p>State Findings:</p> <p>460 IAC 9-3-1(b) The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p> <p>The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division.</p> <p>This state rule is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed for 1 of 3 sampled clients (client C), to report a fall with injury to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Incident reports</p>	W009999	QDDPwill be retrained on conducting thorough investigations and the procedure for submitted BDDS reports, within the 24 hourtimeframe.	12/29/2014

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	<p>and investigations was conducted on 11/14/14 at 1:00 P.M. and indicated:</p> <p>-IR dated 8/25/14 involving client C indicated: "[Client C] was sitting at the dinner table, stood up, [Staff #13] and [Staff #14] both ran towards him, but before he was even standing up all the way, and before we could get to him, he started having a seizure and fell backwards and hit the ground. We called [Staff #15] in the room and were prompting him to try to get a response. Timed the seizure at a minute and a half, and when it was over he started talking and curled up on the floor. He landed mostly on his left elbow and had red marks in both places." Further review of the report failed to indicate this fall with injury was reported to BDDS.</p> <p>A review of the Bureau of Developmental Disabilities Services (BDDS) reporting policy effective March 1, 2011 was conducted on 11/20/14 at 5:50 P.M.. The policy indicated: "It is the policy of the Bureau of Quality Improvement Services (BQIS) to utilize an incident reporting and management system as an integral tool in ensuring the health and welfare of the individuals receiving services administered by BDDS....Incidents to be reported to BDDS... Incidents to be reported to</p>						

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	<p>BQIS include any event or occurrence characterized by risk or uncertainty resulting in of having the potential to result in significant harm or injury to an individual including but not limited to: -"Incidents to be reported to BQIS include any event or occurrence characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to an individual including but not limited to:</p> <p>15. A fall resulting in injury, regardless of the severity of the injury.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 11/24/14 at 12:20 P.M.. The QIDP indicated the incident was not immediately reported to BDDS. The QIDP further indicated the incident should have been reported within 24 hours to BDDS.</p> <p>9-3-1(b)</p>				