

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G640	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 3102 AIRPORT RD PORTAGE, IN 46368
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W000000	<p>This visit was for the investigation of complaint #IN00157771.</p> <p>COMPLAINT #IN00157771: SUBSTANTIATED, Federal and state deficiencies related to the allegation(s) are cited at W104, W149, W153, W154.</p> <p>Unrelated deficiencies cited.</p> <p>Dates of Survey: November 14, 17, 18, 20 and 24, 2014.</p> <p>Facility number: 001220 Provider number: 15G640 AIM number: 100245730</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		

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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W000104	<p>483.410(a)(1) GOVERNING BODY 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 (client B), the governing body failed to ensure the facility's Qualified Intellectual Disabilities Professional (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>	W000104	<p>The QDDP 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>-Investigation record dated 9/13/14 indicated: "Type of allegation: Neglect...Summary of Allegation: It was alleged [Staff #13] did not change [client B]'s undergarment throughout the night as he was found saturated in urine upon shift change. IR dated 9/13/14: 'I came into work today relieving [Staff #13]. I went to the back to [client B]'s room and he was drenched in his urine. I looked in his garbage can that sits right next to his bed and there was no undergarment in there. I then asked [staff #13] was [client B] changed because he needs to be changed every two hours. She stated that she did but [client B] had urine all the way up his back.' Determination: Consumer Rights violated, Agency policies not followed, State policies not followed, Services not appropriately provided. Recommendation: It is recommended that due to lack of documentation to prove [Staff #13] changed [client B], the allegation is substantiated. She will receive corrective action."</p> <p>A review of client B's record was conducted on 11/14/14 at 7:15 P.M. Review of the record indicated staff did not do any bed check, body check and two hour toileting documentation for 9/13/14.</p>			

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	<p>-Investigation record dated 10/8/14 involving client B indicated: "Type of allegation: neglect...Summary of Allegation: It was alleged that [Staff #13] left for transport and forgot that [client B] was in home in bed sick. Determination: Consumer Rights violated, Agency policies not followed, State policies not followed, Services not appropriately provided. Recommendation: It is recommended that the allegation of neglect be substantiated. [Staff #13] was terminated effective immediately the next day."</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 forwards it directly to the investigator, who then submits a BDDS report. The QIDP stated the QIDPs are "never made</p>			

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	<p>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.</p> <p>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 meets, 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. QIDP #2 further indicated the QIDPs are not made aware of conclusions of investigation and do not know what corrective measures are put in place.</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 IRs 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 the decides if the staff is to be terminated or requires retraining and whatever disciplinary actions should be taken. When asked if</p>						

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W000149	<p>the IDT is made aware of the incidents of 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 #IN00157771.</p> <p>9-3-1(a)</p> <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, B and E), the facility failed to implement written policy and procedures in regards to preventing staff neglect and conducting thorough investigations of injuries of unknown</p>	W000149	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	12/29/2014

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	<p>origin and preventing client to client aggression.</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 7:00 P.M. and indicated:</p> <p>1. -Investigation record dated 9/13/14 indicated: "Type of allegation: Neglect...Summary of Allegation: It was alleged [Staff #13] did not change [client B]'s undergarment throughout the night as he was found saturated in urine upon shift change. IR dated 9/13/14: 'I came into work today relieving [Staff #13]. I went to the back to [client B]'s room and he was drenched in his urine. I looked in his garbage can that sits right next to his bed and there was no undergarment in there. I then asked [staff #13] was [client B] changed because he needs to be changed every two hours. She stated that she did but [client B] had urine all the way up his back.' Determination: Consumer Rights violated, Agency policies not followed, State policies not followed, Services not appropriately provided. Recommendation: It is recommended that due to lack of documentation to prove [Staff #13]</p>		<p>injury of unknown origin. The agency will continue to ensure participants are not subjected 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 the 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>changed [client B], the allegation is substantiated. She will receive corrective action."</p> <p>A review of client B's record was conducted on 11/14/14 at 7:15 P.M.. Review of the record indicated staff did not do any bed check, body check and two hour toileting documentation for 9/13/14.</p> <p>-Investigation record dated 10/8/14 involving client B indicated: "Type of allegation: neglect...Summary of Allegation: It was alleged that [Staff #13] left for transport and forgot that [client B] was in home in bed sick. Determination: Consumer Rights violated, Agency policies not followed, State policies not followed, Services not appropriately provided. Recommendation: It is recommended that the allegation of neglect be substantiated. [Staff #13] was terminated effective immediately the next day."</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 and proper supervision of all clients at the group home. The</p>						

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	<p>investigation indicated it was discovered through the investigation staff at the group home were not properly documenting bed checks, body checks and two hour toileting. The investigator further indicated staff are never to leave clients unsupervised at any time.</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 1:50 P.M. and 7:00 P.M. and indicated:</p> <p>Incidents of injury of unknown origin:</p> <p>-IR dated 8/2/14 indicated: "I found a 1/2 inch by 1/2 inch bruise on [client A]'s left lower eye. I asked [client A] how he receive (sic) the injury. [Client A] (sic) response was he fell. I then asked [client A] who he fell with to which he responded [Group Home Manager name (GHM)]. I then asked [client A] when this took place because [GHM] did not work Friday when he said that he fell (sic) [client A] then laughed and staff asked again what happened. (sic) To which he responded he did not know. The injury was not noted in the previous paperwork but he did have a (sic) outing with his mother that day." Further review of the report failed to indicate an</p>			

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	<p>investigation was conducted in regard to the injury of unknown origin.</p> <p>-IR dated 9/1/14 involving client E indicated: "Staff was doing a body check at 6:45 P.M. for [client E] when staff found a new bruise that is 1.5" (inches) x (by) 2". Staff asked [client E] how she received the bruise to which [client E] responded that she did not know. Staff asked [client E] if it hurt when I touched it. She responded no. The bruise is on her right shin." Further review of the report failed to indicate an investigation was conducted in regard to the injury of unknown origin.</p> <p>-BDDS report dated 9/7/14 involving client E indicated: "Staff reports [client E] has an 8 by 7 inch bruise on her left shin. it's (sic) a dark purplish color. the (sic) bruise is about the size of a palm. it (sic) appeared to be healing yesterday then today when I noticed it, the bruise had gotten bigger. The bruise was found by [Staff #14] September 5th, 2014. When found it was 2 3/4 by 1 inch and swollen around....We asked [client E] what happened and she said it happened at workshop." Further review of the report failed to indicate an investigation was conducted in regard to the injury of unknown origin.</p>						

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	<p>-IR dated 9/16/14 indicated: "While Giving (sic) [client E] a shower I noticed a dark purple bruise on the back of her leg. I measured it, it was 1 1/2 x 1 1/2 inch. I asked her if she knew how she got it, she said she didn't know." Further review of the report failed to indicate an investigation was conducted in regard to the injury of unknown origin.</p> <p>-BDDS report dated 9/18/14 involving client E indicated: "On 9/18/14 at approximately 8:30 P.M.. [Staff name] contacted [Qualified Developmental Disabilities Professional (QIDP)] and explained the 1.5 inch by 1.5 inch bruise discovered on 9/16/14, [client E] had on her left calf had expanded to 3 inches by 2 inches. QDDP instructed staff to put ice on it if [client E] was complaining of pain and to file an incident report. It is undetermined what caused the bruising." Further review of the report failed to indicate a thorough investigation was conducted in regards 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.. The QIDP indicated staff should follow the facility's abuse/neglect policy. When asked if there was written documentation to indicate thorough</p>						

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	<p>investigations were completed in regards to the incidents of injuries of unknown origin, she indicated there was no documentation.</p> <p>3. A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports, Internal Reports (IR) and investigation records was conducted on 11/14/14 at 7:00 P.M.. Review of the records indicated:</p> <p>Incidents of client to client aggression:</p> <p>-IR dated 8/8/14 involving client A and a facility owned day program client indicated: "[Facility owned day program client #1] was pinching another participant (client A) on the arm and squeezing his finger."</p> <p>-IR dated 8/22/14 involving client A and a facility owned day program client indicated: "[Client A] was sitting up by my desk. [Facility owned day program client #1] came up to my desk and started pinching [client A]. reason (sic) unknown. [Client A] does have red marks on his arm."</p> <p>-IR dated 8/26/14 involving client A and a facility owned day program client indicated: "Both participants where (sic) sitting at the table. when (sic) I saw</p>						

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	<p>[Facility owned day program client #1] pinching and grabbing [client A]'s arm. there (sic) was (sic) visible red marks. [Facility owned day program client #1] did try to bite [client A] but I was able to stop him."</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 all clients are to be free from physical aggression and indicated staff should ensure clients are not aggressed upon.</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</p>				

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	<p>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 Services within 5 working days following the report of the incident."</p> <p>This federal tag relates to complaint #IN00157771.</p> <p>9-3-2(a)</p>			

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W000153	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.			

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(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 and interview, the facility failed for 2 of 3 sampled clients (clients A and B), and 1 additional client (client E) to report injuries of unknown origin immediately 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 1:50 P.M. and 7:00 P.M. and indicated:</p> <p>-IR dated 8/2/14 indicated: "I found a 1/2 inch by 1/2 inch bruise on [client A]'s left lower eye. I asked [client A] how he receive (sic) the injury. [Client A] (sic) response was he fell. I then asked [client A] who he fell with to which he responded [Group Home Manager name (GHM)]. I then asked [client A] when this took place because [GHM] did not work Friday when he said that he fell (sic) [client A] then laughed and staff asked again what happened. (sic) To which he responded he did not know. The injury was not noted in the previous paperwork but he did have a (sic) outing</p>	W000153	QDDPwill be retrained on conducting thorough investigations of injuries of unknownorigin and the procedure for submitted BDDS reports, within the 24 hourstimeframe. To ensure a thoroughinvestigation, the QDDP will immediately be trained on and required to attachan "Investigative Report Form" (see attached form) to each investigationregarding an injury of unknown origin.	12/29/2014	

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	<p>with his mother that day." Further review of the report failed to indicate this injury of unknown origin was reported to BDDS.</p> <p>-IR dated 8/11/14 indicated: "While working in the [Day Program] I noticed that [client B] had a scratch on the top almost tip of his nose which he did not have just minutes before. I did not see it happen but I think [client B] missed his mouth and scratched his nose while signing eat." Further review of this report failed to indicate this injury of unknown origin was reported to BDDS.</p> <p>-IR dated 9/1/14 involving client E indicated: "Staff was doing a body check at 6:45 P.M. for [client E] when staff found a new bruise that is 1.5" (inches) x (by) 2". Staff asked [client E] how she received the bruise to which [client E] responded that she did not know. Staff asked [client E] if it hurt when I touched it. She responded no. The bruise is on her right shin."</p> <p>-IR dated 9/5/14 indicated: "[Client E] was in the computer room while staff stepped out to assist another participant on another computer. When staff returned [client E] appeared to have fallen out of her chair and was sitting on the floor on her butt. Staff checked for</p>						

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	<p>marks and asked if she was okay and if anything hurt. Also there were no marks on her back or butt. There was a bruise on the inside of her of her right leg that was dark in color but did not appear to be from the fall." Further review of this report failed to indicate this unwitnessed fall with injury/injury of unknown origin was reported to BDDS.</p> <p>-BDDS report dated 9/7/14 involving client E indicated: "Staff reports [client E] has an 8 by 7 inch bruise on her left shin. it's (sic) a dark purplish color. the (sic) bruise is about the size of a palm. it (sic) appeared to be healing yesterday then today when I noticed it, the bruise had gotten bigger. The bruise was found by [Staff #14] September 5th, 2014. When found it was 2 3/4 by 1 inch and swollen around....We asked [client E] what happened and she said it happened at workshop."</p> <p>-IR dated 9/16/14 indicated: "While Giving (sic) [client E] a shower I noticed a dark purple bruise on the back of her leg. I measured it, it was 1 1/2 x 1 1/2 inch. I asked her if she knew how she got it, she said she didn't know."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 11/24/14 at</p>						

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W000154	<p>12:20 P.M.. The QIDP indicated there was no written documentation to indicate the injuries of unknown origin were reported to BDDS. The QIDP further indicated the injuries of unknown origin should have been reported to BDDS within 24 hours.</p> <p>This federal tag relates to complaint #IN00157771.</p> <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.</p> <p>Based on record review and interview for 2 of 3 sampled clients (clients A and B), and 1 additional client (client E), the facility failed to provide written evidence thorough investigations were conducted in regard to an allegation of staff neglect and injuries of unknown origin.</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	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>1. -Investigation record dated 9/13/14 indicated: "Type of allegation: Neglect...Summary of Allegation: It was alleged [Staff #13] did not change [client B]'s undergarment throughout the night as he was found saturated in urine upon shift change. IR dated 9/13/14: 'I came into work today relieving [Staff #13]. I went to the back to [client B]'s room and he was drenched in his urine. I looked in his garbage can that sits right next to his bed and there was no undergarment in there. I then asked [staff #13] was [client B] changed because he needs to be changed every two hours. She stated that she did but [client B] had urine all the way up his back.' Determination: Consumer Rights violated, Agency policies not followed, State policies not followed, Services not appropriately provided. Recommendation: It is recommended that due to lack of documentation to prove [Staff #13] changed [client B], the allegation is substantiated. She will receive corrective</p>		will be retrained onconducting thorough investigations of injuries of unknown origin. To ensure a thorough investigation, the QDDPwill immediately be trained on and required to attach an "Investigative ReportForm" (see attached form) to each investigation regarding an injury of unknownorigin.				

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	<p>action."</p> <p>A review of client B's record was conducted on 11/14/14 at 7:15 P.M.. Review of the record failed to indicate all staff who worked at the group home were interviewed and all clients were interviewed.</p> <p>-Investigation record dated 10/8/14 involving client B indicated: "Type of allegation: neglect...Summary of Allegation: It was alleged that [Staff #13] left for transport and forgot that [client B] was in home in bed sick. Determination: Consumer Rights violated, Agency policies not followed, State policies not followed, Services not appropriately provided. Recommendation: It is recommended that the allegation of neglect be substantiated. [Staff #13] was terminated effective immediately the next day." Further review of the record failed to indicate all staff who worked at the group home were interviewed and all clients 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</p>						

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	<p>documentation and proper supervision of all clients at the group home. The investigation indicated it was discovered through the investigation staff at the group home were not properly documenting bed checks, body checks and two hour toileting. The investigator further indicated staff are never to leave clients unsupervised at any time. When asked if all staff who worked at the group home were interviewed, the investigator indicated they were not. When asked if the clients who reside at the home were interviewed, the investigator indicated they were not.</p> <p>2. A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports, Internal Reports (IR) and investigation records was conducted on 11/14/14 at 1:50 P.M.. Review of the records indicated:</p> <p>Incidents of injury of unknown origin:</p> <p>-IR dated 8/2/14 indicated: "I found a 1/2 inch by 1/2 inch bruise on [client A]'s left lower eye. I asked [client A] how he receive (sic) the injury. [Client A] (sic) response was he fell. I then asked [client A] who he fell with to which he responded [Group Home Manager name (GHM)]. I then asked [client A] when this took place because [GHM] did not</p>			

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	<p>work Friday when he said that he fell (sic) [client A] then laughed and staff asked again what happened. (sic) To which he responded he did not know. The injury was not noted in the previous paperwork but he did have a (sic) outing with his mother that day." Further review of the report failed to indicate an investigation was conducted in regard to the injury of unknown origin.</p> <p>-IR dated 9/1/14 involving client E indicated: "Staff was doing a body check at 6:45 P.M. for [client E] when staff found a new bruise that is 1.5" (inches) x (by) 2". Staff asked [client E] how she received the bruise to which [client E] responded that she did not know. Staff asked [client E] if it hurt when I touched it. She responded no. The bruise is on her right shin." Further review of the report failed to indicate an investigation was conducted in regard to the injury of unknown origin.</p> <p>-BDDS report dated 9/7/14 involving client E indicated: "Staff reports [client E] has an 8 by 7 inch bruise on her left shin. it's (sic) a dark purplish color. the (sic) bruise is about the size of a palm. it (sic) appeared to be healing yesterday then today when I noticed it, the bruise had gotten bigger. The bruise was found by [Staff #14] September 5th, 2014.</p>						

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	<p>When found it was 2 3/4 by 1 inch and swollen around....We asked [client E] what happened and she said it happened at workshop." Further review of the report failed to indicate an investigation was conducted in regard to the injury of unknown origin.</p> <p>-IR dated 9/16/14 indicated: "While Giving (sic) [client E] a shower I noticed a dark purple bruise on the back of her leg. I measured it, it was 1 1/2 x 1 1/2 inch. I asked her if she knew how she got it, she said she didn't know." Further review of the report failed to indicate an investigation was conducted in regard to the injury of unknown origin.</p> <p>-BDDS report dated 9/18/14 involving client E indicated: "On 9/18/14 at approximately 8:30 P.M.. [Staff name] contacted [Qualified Developmental Disabilities Professional (QIDP)] and explained the 1.5 inch by 1.5 inch bruise discovered on 9/16/14, [client E] had on her left calf had expanded to 3 inches by 2 inches. QDDP instructed staff to put ice on it if [client E] was complaining of pain and to file an incident report. It is undetermined what caused the bruising." Further review of the report failed to indicate a thorough investigation was conducted in regards to the injury of unknown origin.</p>			

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W000189	<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 #IN00157771.</p> <p>9-3-2(a)</p> <p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based on record review and interview, the facility failed for 1 of 3 sampled clients and 1 additional client (clients B and D), to ensure staff were sufficiently</p>	W000189	The agency ensures that all newly hired staff are trained in Medcore A & B, with mandatory recertification's once a year. The nursing department, as they see	12/22/2014

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	<p>trained to 1. assure competence in proper administration of medications as ordered, 2. to assure competency in documentation and providing care of clients.</p> <p>Findings include:</p> <p>1. A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports, Internal Reports (IR) and investigation records was conducted on 11/14/14 at 1:50 P.M.. Review of the records indicated:</p> <p>-IR dated 8/19/14 involving client B indicated: "Staff didn't pass [client B]'s 8:00 P.M. Vimpat (epilepsy) 200 mg (milligram) controlled medication....The responsible party will be issued a corrective action and/or re-training per agency policy."</p> <p>-BDDS report dated 9/18/14 involving client D indicated: "...On 9/18/14 at approximately 8:30 P.M., [Group Home Manager (GHM)] called [Qualified Developmental Disabilities Professional (QDDP)] and explained the (sic) [client D] had ingested Risperidone 1 mg (schizophrenia), Olanzapine (bipolar) 20 mg and Crestor (high cholesterol) 10 mg; his medications scheduled for 9/19/14 at 6:00 P.M.. The medication was being</p>		<p>fit, willretrain staff who have committed an error during a medicationadministration.</p>				

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	<p>pre-packed by [Staff name] for an outing taking place on 9/19/14. When [client D] was called into the restroom to brush his teeth, the medication was not yet packed or secured and [client D] reached around staff, grabbed the medication and ingested it. [Nurse name] was contacted and she instructed staff to monitor for any adverse effects of the extra medication....Corrective action and/or training will be given to responsible staff. A review of agency policy regarding the packaging of medication for outings will also occur. High risk protocol and training for diagnosis of PICA (ingestion of inedible objects) will be reviewed...."</p> <p>A review of the facility's "Universal Policies and Procedures-Medication Administration" dated 8/8/13 was conducted on 11/17/14 at 8:15 P.M.. Review of the policy indicated: "Opportunity Enterprises clients will receive medications as prescribed by the individuals attending physician's to maintain optimum health....B. Guidelines for dispensing medications for all consumers:</p> <p>1. Prescription medications will be administered as instructed on the pharmacy label and non-prescription medications will be administered using labeled instructions unless changed by</p>						

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	<p>the ordering physician.</p> <p>8. Medications will be verified 3 times against the Medication Administration Record. This includes medications that are set in the weekly pill dispenser.</p> <p>C. Dispensing of Medications:</p> <p>4. The medication should be checked three times in accordance with med core training.</p> <p>a. When taking out the medication.</p> <p>b. After pouring or punching out the medication.</p> <p>c. Before administering the medication to the client.</p> <p>6. The 6 rights of medication administration should be followed.</p> <p>a. Right medication is given to the;</p> <p>b. Right person at the;</p> <p>c. Right time;</p> <p>d. Right dose/strength;</p> <p>e. Right route.</p> <p>An interview with the agency nurse was conducted on 11/24/14 at 12:20 P.M.. The nurse indicated staff should have administered client B's Vimpat medication as ordered. The nurse indicated staff should not have pre-prepared client D's medications and further indicated client D should not have</p>						

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	<p>been prompted into the medication room bathroom while medications were being handled. The nurse further indicated staff should have followed the facility's medication administration policy.</p> <p>9-3-3(a)</p>			
W000368	<p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview, the facility failed to assure drugs administered to 1 of 2 sampled clients and 1 additional client (clients B and D) were administered in compliance with the physician's orders.</p>	W000368	All staff identified in the reports listed under citation 368, have been retrained, per the nursing department's recommendations.	12/22/2014

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	<p>Findings include:</p> <p>A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports, Internal Reports (IR) and investigation records was conducted on 11/14/14 at 1:50 P.M.. Review of the records indicated:</p> <p>-IR dated 8/19/14 involving client B indicated: "Staff didn't pass [client B]'s 8:00 P.M. Vimpat (epilepsy) 200 mg (milligram) controlled medication....The responsible party will be issued a corrective action and/or re-training per agency policy."</p> <p>-BDDS report dated 9/18/14 involving client D indicated: "...On 9/18/14 at approximately 8:30 P.M., [Group Home Manager (GHM)] called [Qualified Developmental Disabilities Professional (QDDP)] and explained the (sic) [client D] had ingested Risperidone 1 mg (schizophrenia), Olanzapine (bipolar) 20 mg and Crestor (high cholesterol) 10 mg; his medications scheduled for 9/19/14 at 6:00 P.M.. The medication was being pre-packed by [Staff name] for an outing taking place on 9/19/14. When [client D] was called into the restroom to brush his teeth, the medication was not yet packed or secured and [client D] reached around</p>			
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NAME OF PROVIDER OR SUPPLIER OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3102 AIRPORT RD PORTAGE, IN 46368
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	<p>staff, grabbed the medication and ingested it. [Nurse name] was contacted and she instructed staff to monitor for any adverse effects of the extra medication....Corrective action and/or training will be given to responsible staff. A review of agency policy regarding the packaging of medication for outings will also occur. High risk protocol and training for diagnosis of PICA (ingestion of inedible objects) will be reviewed...."</p> <p>A review of the facility's "Universal Policies and Procedures-Medication Administration" dated 8/8/13 was conducted on 11/17/14 at 8:15 P.M.. Review of the policy indicated: "Opportunity Enterprises clients will receive medications as prescribed by the individuals attending physician's to maintain optimum health....B. Guidelines for dispensing medications for all consumers:</p> <p>1. Prescription medications will be administered as instructed on the pharmacy label and non-prescription medications will be administered using labeled instructions unless changed by the ordering physician.</p> <p>8. Medications will be verified 3 times against the Medication Administration Record. This includes medications that</p>			

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	<p>are set in the weekly pill dispenser.</p> <p>C. Dispensing of Medications:</p> <p>4. The medication should be checked three times in accordance with med core training.</p> <p style="padding-left: 20px;">a. When taking out the medication.</p> <p style="padding-left: 20px;">b. After pouring or punching out the medication.</p> <p style="padding-left: 20px;">c. Before administering the medication to the client.</p> <p>6. The 6 rights of medication administration should be followed.</p> <p style="padding-left: 20px;">a. Right medication is given to the;</p> <p style="padding-left: 20px;">b. Right person at the;</p> <p style="padding-left: 20px;">c. Right time;</p> <p style="padding-left: 20px;">d. Right dose/strength;</p> <p style="padding-left: 20px;">e. Right route.</p> <p>An interview with the agency nurse was conducted on 11/24/14 at 12:20 P.M.. The nurse indicated staff should have administered client B's Vimpat medication as ordered. The nurse indicated staff should not have pre-prepared client D's medications and further indicated client D should not have been prompted into the medication room bathroom while medications were being handled. The nurse further indicated staff should have followed the facility's medication administration policy.</p>			

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W009999	<p>9-3-6(a)</p> <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 additional client (client E), to report falls with injury and outside medical services to the Bureau of</p>	W009999	QDDP will be retrained on conducting thorough investigations and the procedure for submitted BDDS reports, within the 24 hour timeframe.	12/29/2014
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	<p>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 and investigations was conducted on 11/14/14 at 1:50 P.M. and indicated:</p> <p>-BDDS report dated 8/5/14...Date of Knowledge: 8/5/14...Submitted Date: 8/7/14 involving client E indicated: "[Group Home Manager (GHM)] reports: I was contacted by [Qualified Developmental Disabilities Professional (QDDP)] that [client E] had vomited twice and didn't look like she felt good. She said that her eyes looked super sleepy and droopy. (sic) And I that I need to contact the [Nurse name], because [client E] needs to go home. I called [Physician name] to let her know that [client E] had been vomiting up red globs at [Day Program]. She informed me to take her to the Emergency Room. They took Labs and Chest X-rays. The X-rays showed she has pneumonia. She was admitted to [Hospital name]." Further review failed to indicate this incident was reported to BDDS in a timely manner.</p> <p>-BDDS report dated 10/3/14...Date of</p>			

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	<p>Knowledge: 10/3/14...Submitted Date: 10/7/14 involving client E indicated: "[Staff name] reports: [Client E] was picked up at 1 pm from workshop and taken to Urgent Care per [Nurse name] and [QDDP] for the swelling in her left shin. The doctor ordered for an xray and the xray came back normal. He also said that he does not think there is an infection in her leg causing the swelling. He advised staff to apply ice or a heating pad to the swollen area for 20 minutes on and 20 minutes off and elevate when possible. I also asked the doctor if there was anything he could do for her constipation and he suggested laxatives and if the laxatives do not work then to try a [Enema name]. [Nurse name] was again contacted and she directed staff to give [enema name] at 3:35 pm for 14 shifts with no BM (bowel movement). At 4 PM [client E] had a XL (extra large) bowel movement." Further review failed to indicate this incident was reported to BDDS in a timely manner.</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</p>						

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	<p>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 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:</p> <p>- "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>11. An emergency intervention for the individual resulting from:</p> <ol style="list-style-type: none"> a physical symptom; a medical or psychiatric condition; any other event." <p>14. A significant injury to an individual that includes but is not limited to:</p> <ol style="list-style-type: none"> bruises or contusions larger than 3 inches in any direction, or a pattern of bruises or contusions regardless of size." <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</p>			

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	<p>incidents were not immediately reported to BDDS. The QIDP further indicated the incidents should have been reported within 24 hours to BDDS.</p> <p>9-3-1(b)</p>			