

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G511	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/31/2013
NAME OF PROVIDER OR SUPPLIER OPPORTUNITY ENTERPRISES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5949 FIESTA AVE PORTAGE, IN 46368		
(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	
W000000	<p>This visit was for the investigation of complaint #IN00127728.</p> <p>COMPLAINT #IN00127728: SUBSTANTIATED, Federal/State deficiencies related to the allegation are cited at W104 and W149.</p> <p>Unrelated deficiency cited.</p> <p>Dates of Survey: May 17, 21, 29 and 31, 2013.</p> <p>Facility number: 001025 Provider number: 15G511 AIM number: 100245170</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 6/7/13 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G511		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/31/2013	
NAME OF PROVIDER OR SUPPLIER OPPORTUNITY ENTERPRISES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5949 FIESTA AVE PORTAGE, IN 46368			
(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			
W000104	<p>483.410(a)(1) 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 2 of 3 sampled clients (clients A and B), the governing body failed to exercise general policy and operating direction over the facility to ensure staff implemented the facility's "Dispensing Medication" policy, to prevent neglect of clients A and B and neglected to conduct a thorough investigation of an incident which resulted in injury.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted on 5/17/13 at 1:45 P.M.. Review of 1 of 1 investigation record submitted for review indicated:</p> <p>Bureau of Developmental Disabilities Services (BDDS) report dated 4/11/13: "At the scheduled 7 P.M. med pass, [client A] entered the med room and took his prescribed medications, then went back out to the couch in the recreation room. His roommate's meds were then prepared for administration (they were put in pudding). The roommate refused the meds so staff 'hid' the pudding cup in between a tissue box and another small box in the medication room. She left the</p>	W000104	<p>W104-The agency policies regarding dispensing medication and abuse and neglect will be reviewed at the next group home staff meeting on 6/26/2013. It will be emphasized that all meds are to be properly secured at all times. To ensure further compliance, the GH Manager will randomly monitor med passes to ensure meds are properly secured. The QDDPD , GH Nurse and Lead Manager will also monitor at monthly house visits. All staff will attend the annual trainings on abuse and neglect and medication review. Human Resources and the GH Manager will monitor to ensure staff is in compliance with their annual trainings.</p>	06/30/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G511	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/31/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5949 FIESTA AVE PORTAGE, IN 46368
---	---

(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>room to get the roommate to prompt him one more time to take his meds. After just a brief moment, she returned to the med room to find [client A] had found the pudding cup and was licking the spoon clean. He had a small amount of pudding on his mouth and shirt but was throwing away an otherwise empty pudding cup...Plan to Resolve: The staff immediately called the pager and the nurse instructed him to be taken to the ER (Emergency Room). He was taken immediately. Upon arrival, his vitals were BP (blood pressure) 89/30 HR (heart rate) 38. He was given Atropene which raised his BP to 100/43 and the HR to 65. Also low was his blood sugar. The Physician states that the cause of his decreased blood sugar was his taking the roommate's Metformin even though he is not diabetic. In addition to the Metformin, [client A] ingested the roommate's seizure meds. [Client A] was determined to be stable and then transported to an ICU (intensive care unit) room at [Hospital name] for observation. The physician has not been in to see him yet today. Additional information will be submitted for follow-up upon discovery. Staff immediately admitted to the details of the event and removed herself from client contact. The manager then immediately counseled her on how she should have handled the the (sic)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G511		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/31/2013	
NAME OF PROVIDER OR SUPPLIER OPPORTUNITY ENTERPRISES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5949 FIESTA AVE PORTAGE, IN 46368			
(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>roommate's refusal to take the meds and how meds should never be left unattended in a locked med room. Staff will receive corrective action to be placed in her personnel file and will be suspended from med passes until she can be retrained on Med passing."</p> <p>"[Client A]: Findings: Unsubstantiated: Date of Investigation: 4/11/13 Type of Allegation: Neglect Date of Alleged incident: 4/11/13.</p> <p>Summary of Allegation: It was alleged that [Direct Support Professional #1] left prepared medications for one of [client A]'s roommates in a pudding cup and unattended. [Client A] digested the cup (sic).</p> <p>Investigative summary: [DSP #1] called the ER pager to self report a med error. She was conducting the 7 P.M. med pass and prepared [client E]'s meds in a pudding cup per instructions. [Client E] refused to take his meds and so [DSP #1] set the pudding cup down between a tissue box and another box of personal cleansing cloths. She left the med room to go find [client E] to encourage him to take his meds. When she returned, she observed [client A] licking the spoon and throwing away an empty pudding cup. [DSP #1] states [client A] had already</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G511	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/31/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5949 FIESTA AVE PORTAGE, IN 46368
---	---

(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>consumed his own medications and was out in the rec area sitting in the chair. She admits that she did not lock up the prepared meds.</p> <p>Determination: Agency policies not followed...Services not appropriately provided."</p> <p>A review of the facility's undated "Dispensing Medication" policy was conducted on 5/21/13 at 9:50 A.M.. Review of the policy indicated: "Opportunity Enterprises, Inc., will ensure the safe and accurate administration of medication in Supervised Living location. The following procedure should be followed when staff administers medication...If you leave the medications area-it must be locked. Do not leave any medication out, away from you."</p> <p>An interview with the Qualified Intellectual Disabilities Professional Designee (QIDPD) was conducted on 5/29/13 at 3:30 P.M.. The QIDPD indicated staff should have locked the medication room door when she exited the room to prevent client A from ingesting client E's oral medications.</p> <p>Please refer to W149. The facility neglected for 2 of 3 sampled clients (clients A and B) to implement written</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G511	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/31/2013
NAME OF PROVIDER OR SUPPLIER OPPORTUNITY ENTERPRISES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5949 FIESTA AVE PORTAGE, IN 46368		
(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>policy and procedures to prevent neglect of a client A, who ingested client E's oral prescribed medications. The facility neglected to conduct a thorough investigation for client B's fall which resulted in an injury and required medical attention.</p> <p>Please refer to W154. The facility failed for 1 of 2 incidents, involving 1 of 3 sampled clients (client B) to provide written evidence a thorough investigation was conducted.</p> <p>This federal tag relates to complaint #IN00127728.</p> <p>9-3-1(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G511		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/31/2013	
NAME OF PROVIDER OR SUPPLIER OPPORTUNITY ENTERPRISES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5949 FIESTA AVE PORTAGE, IN 46368			
(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			
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 (clients A and B), the facility neglected to 1. prevent client A from ingesting client E's prescribed oral medications, 2. to ensure implementation of their policy and procedures and 3. to prevent client B from falling which resulted in injury.</p> <p>Findings include:</p> <p>1. A review of the facility's records was conducted on 5/17/13 at 1:45 P.M.. Review of 1 of 1 investigation record submitted for review indicated:</p> <p>Bureau of Developmental Disabilities Services (BDDS) report dated 4/11/13: "At the scheduled 7 P.M. med pass, [client A] entered the med room and took his prescribed medications, then went back out to the couch in the recreation room. His roommate's meds were then prepared for administration (they were put in pudding). The roommate refused the meds so staff 'hid' the pudding cup in between a tissue box and another small box in the medication room. She left the room to get the roommate to prompt him one more time to take his meds. After</p>	W000149	<p>W 149</p> <p>1. Please see plan of correction W 104</p> <p>2. Please see plan of correction W 104</p> <p>3. The QDDPD will review at the next group home staff meeting on 6/26/13 the importance of staff checking the alarm and batteries daily to ensure it is in proper working order. The battery check is to be documented on the MAR. When consumer B is in her bedroom staff will conduct 30 minute checks to ensure the client's safety. To ensure further compliance, the GH Manager will conduct random checks on the alarm and ensure 30 minute checks are being conducted by staff. The QDDPD and Lead Manager will also monitor at monthly house visits to ensure compliance with these items.</p>	06/30/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G511	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/31/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5949 FIESTA AVE PORTAGE, IN 46368
---	---

(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>just a brief moment, she returned to the med room to find [client A] had found the pudding cup and was licking the spoon clean. He had a small amount of pudding on his mouth and shirt but was throwing away an otherwise empty pudding cup...Plan to Resolve: The staff immediately called the pager and the nurse instructed him to be taken to the ER (Emergency Room). He was taken immediately. Upon arrival, his vitals were BP (blood pressure) 89/30 HR (heart rate) 38. He was given Atropene which raised his BP to 100/43 and the HR to 65. Also low was his blood sugar. The Physician states that the cause of his decreased blood sugar was his taking the roommates' Metformin even though he is not diabetic. In addition to the Metformin, [client A] ingested the roommate's seizure meds. [Client A] was determined to be stable and then transported to an ICU (intensive care unit) room at [Hospital name] for observation. The physician has not been in to see him yet today. Additional information will be submitted for follow-up upon discovery. Staff immediately admitted to the details of the event and removed herself from client contact. The manager then immediately counseled her on how she should have handled the the (sic) roommate's refusal to take the meds and how meds should never be left unattended</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G511		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/31/2013	
NAME OF PROVIDER OR SUPPLIER OPPORTUNITY ENTERPRISES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5949 FIESTA AVE PORTAGE, IN 46368			
(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>in a locked med room. Staff will receive corrective action to be placed in her personnel file and will be suspended from med passes until she can be retrained on Med passing."</p> <p>"[Client A]: Findings: Unsubstantiated: Date of Investigation: 4/11/13 Type of Allegation: Neglect Date of Alleged incident: 4/11/13.</p> <p>Summary of Allegation: It was alleged that [Direct Support Professional #1] left prepared medications for one of [client A]'s roommates in a pudding cup and unattended. [Client A] digested the cup (sic).</p> <p>Investigative summary: [DSP #1] called the ER pager to self report a med error. She was conducting the 7 P.M. med pass and prepared [client E]'s meds in a pudding cup per instructions. [Client E] refused to take his meds and so [DSP #1] set the pudding cup down between a tissue box and another box of personal cleansing cloths. She left the med room to go find [client E] to encourage him to take his meds. When she returned, she observed [client A] licking the spoon and throwing away an empty pudding cup. [DSP #1] states [client A] had already consumed his own medications and was out in the rec area sitting in the chair. She</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G511	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/31/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5949 FIESTA AVE PORTAGE, IN 46368
---	---

(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>admits that she did not lock up the prepared meds.</p> <p>Determination: Agency policies not followed...Services not appropriately provided."</p> <p>2. BDDS report dated 5/12/13: "[Client B] was lying in her bed and for reason unknown she decided to get up by herself and the bed alarm did not sound. Staff heard her talking, both; loudly and clearly so staff went to check on her and she was lying on the floor bleeding. One staff member applied pressure to [client B]'s head and another staff was on the phone with 911 calling for help...Plan to Resolve: [Client B] was taken to [Hospital name] via ambulance. While at the hospital a CT scan (xray) was completed and it came back negative. [Client B] had a vertical laceration posterior occipital scalp 1 cm (centimeter) in length, she received 2 staples. She was diagnosed with a Hematoma. She is to follow up with her GP (general practitioner) within 3 days...I spoke with the group home manager and asked her if she knew why the alarm did not go off, she did not. She had the staff check several different ways to see if there was a problem with the alarm. The alarm worked every time staff tried it. It is unclear as to why this particular incident</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G511		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/31/2013	
NAME OF PROVIDER OR SUPPLIER OPPORTUNITY ENTERPRISES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5949 FIESTA AVE PORTAGE, IN 46368			
(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>the alarm did not go off to alert staff that [client B] got out of her bed...When she (direct support professional) went into [client B]'s room that is when she saw [client B] by her bedroom door with the noted head injury...Staff stated that she (client B) had fallen but they did not hear her fall."</p> <p>A review of the facility's undated "Universal Policies and Procedures-Adult Services-Abuse and Neglect", was conducted on 5/17/13 at 5:00 P.M.. Review of the policy indicated: "Opportunity Enterprises, Inc. does not condone and will not tolerate physical, verbal or sexual abuse, neglect or exploitation of individuals served....Definition-Neglect: Includes the refusal or failure to provide appropriate care, food, medical care or supervision."</p> <p>An interview with the Qualified Intellectual Disabilities Professional Designee (QIDPD) was conducted on 5/29/13 at 3:30 P.M.. The QIDPD indicated staff should have locked the medication room door when she exited the room to prevent client A from ingesting client E's oral medications. The QIDPD further indicated staff was not in the room with client B when she fell, was unsure how she fell and did not know why the bed alarm did not go off when</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G511	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/31/2013
NAME OF PROVIDER OR SUPPLIER OPPORTUNITY ENTERPRISES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5949 FIESTA AVE PORTAGE, IN 46368		
(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>she got out of her bed.</p> <p>This federal tag relates to complaint #IN00127728.</p> <p>9-3-2(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G511		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/31/2013	
NAME OF PROVIDER OR SUPPLIER OPPORTUNITY ENTERPRISES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5949 FIESTA AVE PORTAGE, IN 46368			
(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			
W000154	<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 1 of 2 incidents, involving 1 of 3 sampled clients (client B) the facility failed to provide written evidence a thorough investigation was conducted.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted on 5/17/13 at 1:45 P.M.. Review of the facility's Bureau of Developmental Disability Services (BDDS) reports indicated the following:</p> <p>1. Client B-BDDS report dated 5/12/13: "[Client B] was lying in her bed and for reason unknown she decided to get up by herself and the bed alarm did not sound. staff (sic) heard her talking, both; loudly and clearly so staff went to check on her and she was lying on the floor bleeding. One staff member applied pressure to [client B]'s head and another staff was on the phone with 911 calling for help...Plan to Resolve: [Client B] was taken to [Hospital name] via ambulance. While at the hospital a CT scan (x-ray) was completed and it came back negative. [Client B] had a vertical laceration posterior occipital scalp 1 cm (centimeter)</p>	W000154	<p>W 154-The QDDPD will complete thorough investigations to ensure all incidents are thoroughly investigated and documented to rule out abuse and neglect. To ensure further compliance, the Vice President of Consumer Services will monitor reports to ensure appropriate investigations are conducted and documented.</p>	06/30/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G511		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/31/2013	
NAME OF PROVIDER OR SUPPLIER OPPORTUNITY ENTERPRISES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5949 FIESTA AVE PORTAGE, IN 46368			
(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>in length, she received 2 staples. She was diagnosed with Hematoma (collection of blood). She is to follow up with her GP (general practitioner) within 3 days.....I spoke with the group home manager and asked her if she knew why the alarm did not go off, she did not. She had the staff check several different ways to see if there was a problem with the alarm. The alarm worked every time staff tried it. It is unclear as to why this particular incident the alarm did not go off to alert staff that [client B] got out of her bed...When she (direct support professional) went into [client B]'s room that is when she saw [client B] by her bedroom door with the noted head injury...Staff stated that she (client B) had fallen but they did not hear her fall." No written documentation was submitted for review to indicate a thorough investigation was conducted.</p> <p>An interview with the Qualified Intellectual Disabilities Professional Designee (QIDPD) was conducted on 5/29/13 at 1:00 P.M.. When asked if she had written documentation to indicate a thorough investigation was conducted, the QIDPD indicated there was no written documentation to indicate a thorough investigation had been conducted.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G511	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/31/2013
NAME OF PROVIDER OR SUPPLIER OPPORTUNITY ENTERPRISES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5949 FIESTA AVE PORTAGE, IN 46368		
(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	
	9-3-2(a)				