

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  04/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383
---	--

(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 an annual recertification and state licensure survey.</p> <p>Dates of Survey: April 10, 11, 14, 15 and 18, 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 4/30/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview, the governing body failed for 2 of 3 sampled clients and 3 additional clients (clients #1, #3, #4, #5 and #6), to exercise general operating direction in a manner to provide oversight to ensure their abuse and neglect policy was implemented.</p>	W000104	W 104 - #1 See plan of correction W149, #2 See plan of correction W154, #3 See plan of correction W157	05/12/2014

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:  15G512		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/18/2014	
NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383			
(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			
W000126	<p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Please refer to W149: The governing body failed for 2 of 3 sampled clients and 2 additional clients (clients #1, #3, #4 and #5), to implement written policy and procedures in regards to staff abuse, not providing nursing services and conducting investigations.</li> <li>2. Please refer to W154: The governing body failed for 2 of 3 sampled clients and 2 additional clients (clients #1, #3, #4 and #5), to provide evidence thorough investigations were conducted for injuries of unknown origin.</li> <li>3. Please refer to W157: The governing body failed for 2 of 3 sampled clients and 3 additional clients (clients #1, #3, #4, #5 and #6), to take sufficient/effective corrective measures in regard to preventing medication errors.</li> </ol> <p>9-3-1(a)</p> <p>483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all</p>						

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  04/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383
---	--

(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>clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.</p> <p>Based on observation and interview for 6 of 6 clients residing at the group home (clients #1, #2, #3, #4, #5 and #6), the facility failed to encourage and teach each client to access their personal finances.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 4/10/14 from 3:30 P.M. until 4:40 P.M.. At 3:40 P.M., Direct Support Professionals (DSPs) #1 and #2 were asked to reconcile clients #1, #2, #3, #4, #5 and #6's personal petty cash funds. DSPs #1 and #2 indicated the clients' personal petty cash funds were locked up and only the acting group home managers could access their personal petty cash funds. When asked how clients were able to utilize their personal finances, DSPs #1 and #2 indicated the acting group home manager would have to access their finances.</p> <p>An interview with the Qualified Intellectual Disabilities Professional Designee (QIDPD) was conducted on 4/18/14 at 12:40 P.M.. The QIDPD indicated the clients should be taught how to manage their personal funds and</p>	W000126	<p>W126 – The participant’s funds are locked to ensure security and can be accessed by the group home manager. To make certain that the participants have money readily available to suit their purchasing needs there is money that is taken out of the agency petty cash. It was decided to have the unsecured funds be from OE and reimbursed by the participant to prohibit the loss of any of the participant finances; as this money is not locked so all staff and participants have access to it. The participant can use the group home petty cash and then the group home manager will adjust the participant’s money and replace the petty cash so there is money consistently available for their use.</p>	05/12/2014

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  04/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383
---	--

(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>should have access at all times to some of their money to make purchases they may want.</p> <p>9-3-2(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 2 additional clients (clients #1, #3, #4 and #5), the facility failed to implement written policy and procedures in regards to staff abuse, neglecting to provide nursing services and conducting investigations.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports and Incident Reports (IR) was conducted on 4/14/14 at 12:40 P.M.. Review of the records indicated:</p> <p>-BDDS report dated 11/3/13 involving client #5 indicated: "On 11/2/13 [client #5] fell down in the bathroom and had a seizure an hour and a half later. He had no marks or bruises but he was walking very unsteady (sic) and seemed to be in</p>	W000149	W149 – On 5/7/14 staff and nursing was trained on Opportunity Enterprises Abuse and Neglect policy. The QDDP emphasized that the policy must be followed at all times. The SGL Director has reviewed with QDDP's that all written documentation on investigations of injuries of unknown origins and allegations of abuse and neglect will be attached to each report and filed accordingly. To ensure further compliance, the SGL Director will also review all reports as they are completed to ensure the facility's abuse and neglect policy is being followed at all times.	05/12/2014

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  04/18/2014	
NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383			
(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>pain anytime he moved or got up. The group home contacted the nurse and she instructed staff to give him 2 ibuprofen every 4 hours. Today 11/3/13 staff noticed [client #5] was walking very unsteady (sic) seemed to be in pain when he gets up or walks around and talking differently. Staff took [client #5] to the ER (Emergency Room) this afternoon at 12:00 P.M.. ER took his blood, did a urine test, took x-rays and did a CAT scan. Everything came back clear except for the X-rays, they showed that [client #5] had a slight case of pneumonia and his lungs were bruised." There was no documentation to indicate the facility's nursing staff assessed client #5 after the documented fall.</p> <p>-BDDS report dated 11/11/13 involving client #3 indicated: "Monday morning at 10:00 A.M. staff from [Day program] called and said [client #3]'s right ring finger nail was infected and he needed to go to Urgent care as soon as he got home...The doctor drained it and prescribed him antibiotics, he also said soak the finger in warm water for 20 minutes 3 to 4 times a day." There was no documentation to indicate the facility's nursing staff assessed client #3's finger.</p> <p>-BDDS report dated 12/1/13 indicated: "Notified that a discontinued medication</p>						

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  04/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383
---	--

(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>Risperdal had been given for days 1-5 in January 2014 by staff supervisor of group home. On 1/5/14; upon further investigation medication administration records have a discontinue order properly displayed on the appropriate date in November; the discontinue order was not carried out and written on the December medication administration record and pharmacy never received doctor's discontinue order for the medication; RESULT December medication administration record listed Risperdal as current daily med = staff did not correct order from November = participant received Risperdal for 35 days after date doctor ordered it to be discontinued."</p> <p>-IR report dated 1/21/14 involving client #4 indicated: "[Client #4] was taking a bath when staff noticed that his big toe and the one next to it on the left foot was slightly swollen, red in color and appeared to have dried blood underneath the skin surrounding the toe. [Client#4] verbalized pain when his toes were touched." Further review of the report failed to indicate an investigation was conducted in regards to the injury of unknown origin.</p> <p>-BDDS report dated 2/2/14 involving client #3 indicated: "As [client #3] got undressed staff did a body check before</p>			

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  04/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383
---	--

(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>putting him in the shower. Staff noticed a purple/blue large bruise on his left buttock. [Client #3]'s roommate indicated that [client #3] fell when trying to take his sheets to the laundry after wetting his bed...I spoke with staff who worked on Sunday 6:00 A.M. to 2:00 P.M., he said that nothing occurred during his shift and he was not aware of the bruise when he came on the midnight shift 2/3/14. ...I checked on [client #3], the bruise measures 6 inches by 5 inches. It is a mixture of colors ranging from blue to purple...The participant that shares a room with [client #3], and he said that [client #3] fell out of his bed on Saturday night, landing on his butt and that he called for the staff to help. The roommate said that the staff helped [client #3] up." Further review of the report failed to indicate a thorough investigation was conducted in regards to the injury of unknown origin.</p> <p>-BDDS report dated 2/17/14 involving client #4 indicated: "It was reported staff 'swatted' [client #4]'s upper arm...The investigation is complete and the allegation of physical abuse has been substantiated. Staff was presented with formal disciplinary action. Staff was returned to work."</p> <p>-IR report dated 3/4/14 involving client</p>			

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  04/18/2014
NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383		
(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>#1 indicated: "[Client #1] slept through the night til 3:30 A.M. and was active in bed. When staff got [client #1] up for his shower, staff noticed a small quarter size bruise on his elbow. This could have been caused by [client #1] hitting his arm on the bedrail." There was no documentation to indicate an investigation was conducted in regards to this injury of unknown origin.</p> <p>-IR dated 3/18/14 involving client #3 indicated: "While doing personal care, changing his cloths (sic) I noticed [client #3] had a number of scratches on his leg. I informed line supervisor who informed to me to wait for [Staff name]." There was no documentation to indicate an investigation was conducted in regards to this injury of unknown origin.</p> <p>-BDDS report dated 4/5/14 involving client #5 indicated: "I received a call from staff who stated that [client #5] had fallen. Over the phone she explained that she had been in the med room and the rest of the staff were assisting the other clients inside from an outing and had sat [client #5] on the couch and removed his helmet. [Client #5] he had been not been (sic) getting up and walking well on his own all this previous week so staff did not expect him to get up without staff assistance. The staff explained to me that</p>				

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  04/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383
---	--

(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 came out of the bedroom when she heard him yelling and saw him lying on the floor. Previous to the fall [client #5] had been sitting on the couch without his helmet on....It was noted that [client #5] had a red bump on the left side of his head as an injury resulting from the fall. Although no one was present to observe the details of the fall, there was a coffee table in [client #5]'s walking path that he may have hit his head on or he may have hit his head on the floor." Further review of the report failed to indicate an investigation was conducted in regards to the injury of unknown origin.</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 4/15/14 at 4:30 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</p>			

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  04/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383
---	--

(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>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 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>An interview with the Qualified Intellectual Disabilities Professional Designee (QIDPD) was conducted on 4/18/14 at 12:40 P.M.. The QIDPD</p>			

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  04/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383
---	--

(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>indicated staff should follow the facility's abuse/neglect policy. The QIDPD indicated the facility's abuse/neglect policy should be followed at all times. When asked if there was written documentation to indicate investigations were completed in regards to the incidents of injuries of unknown origin and allegations of neglect, the QIDPD indicated she did not know because she was recently assigned to this home.</p> <p>9-3-2(a)</p>			
W000154	<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 2 additional clients (clients #1, #3, #4 and #5), the</p>	W000154	W154 – See Plan of corrections W149	05/12/2014

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  04/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383
---	--

(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>facility failed to provide evidence thorough investigations were conducted in regard to allegations of abuse and injuries of unknown origin.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS) and Incident Reports (IR) was conducted on 4/14/14 at 12:40 P.M.. Review of the records indicated:</p> <p>-BDDS report dated 11/11/13 involving client #3 indicated: "Monday morning at 10:00 A.M. staff from [Day program] called and said [client #3]'s right ring finger nail was infected and he needed to go to Urgent care as soon as he got home...The doctor drained it and prescribed him antibiotics, he also said soak the finger in warm water for 20 minutes 3 to 4 times a day." Further review of the report failed to indicate an investigation was conducted in regards to the injury of unknown origin.</p> <p>-BDDS report dated 12/1/13 involving client #4 indicated: "Notified that a discontinued medication Risperdal had been given for days 1-5 in January 2014 by staff supervisor of group home. On 1/5/14; upon further investigation medication administration records have a</p>			

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  04/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383
---	--

(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>discontinue order properly displayed on the appropriate date in November; the discontinue order was not carried out and written on the December medication administration record and pharmacy never received doctor's discontinue order for the medication; RESULT December medication administration record listed Risperdal as current daily med = staff did not correct order from November = participant received Risperdal for 35 days after date doctor ordered it to be discontinued." Further review of the report failed to indicate an investigation was conducted in regard to this allegation of neglect.</p> <p>-IR report dated 1/21/14 involving client #4 indicated: "[Client #4] was taking a bath when staff noticed that his big toe and the one next to it on the left foot was slightly swollen, red in color and appeared to have dried blood underneath the skin surrounding the toe. [Client#4] verbalized pain when his toes were touched." Further review of the report failed to indicate an investigation was conducted in regards to the injury of unknown origin.</p> <p>-BDDS report dated 2/2/14 involving client #3 indicated: "As [client #3] got undressed staff did a body check before putting him in the shower. Staff noticed</p>			

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  04/18/2014	
NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383			
(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>a purple/blue large bruise on his left buttock. [Client #3]'s roommate indicated that [client #3] fell when trying to take his sheets to the laundry after wetting his bed...I spoke with staff who worked on Sunday 6:00 A.M. to 2:00 P.M., he said that nothing occurred during his shift and he was not aware of the bruise when he came on the midnight shift 2/3/14. ...I checked on [client #3], the bruise measures 6 inches by 5 inches. It is a mixture of colors ranging from blue to purple...The participant that shares a room with [client #3] said that [client #3] fell out of his bed on Saturday night, landing on his butt and that he called for the staff to help. The roommate said that the staff helped [client #3] up." Further review of the report failed to indicate an investigation was conducted in regards to the injury of unknown origin.</p> <p>-IR report dated 3/4/14 involving client #1 indicated: "[Client #1] slept through the night til 3:30 A.M. and was active in bed. When staff got [client #1] up for his shower, staff noticed a small quarter size bruise on his elbow. This could have been caused by [client #3] hitting his arm on the bedrail." Further review of the report failed to indicate an investigation was conducted in regards to the injury of unknown origin.</p>						

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  04/18/2014	
NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383			
(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>-IR dated 3/18/14 involving client #3 indicated: "While doing personal care, changing his cloths (sic) I noticed [client #3] had a number of scratches on his leg. I informed line supervisor who informed me to wait for [Staff name]." Further review failed to indicate an investigation was conducted in regards to the injury of unknown origin.</p> <p>-BDDS report dated 4/5/14 involving client #5 indicated: "I received a call from staff who stated that [client #5] had fallen. Over the phone she explained that she had been in the med room and the rest of the staff were assisting the other clients inside from an outing and had sat [client #5] on the couch and removed his helmet. [Client #5] he had been not been (sic) getting up and walking well on his own all this previous week so staff did not expect him to get up without staff assistance. The staff explained to me that she came out of the bedroom when she heard him yelling and saw him lying on the floor. Previous to the fall [client #5] had been sitting on the couch without his helmet on....It was noted that [client #5] had a red bump on the left side of his head as an injury resulting from the fall. Although no one was present to observe the details of the fall, there was a coffee table in [client #5]'s walking path that he</p>						

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  04/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383
---	--

(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
W000157	<p>may have hit his head on or he may have hit his head on the floor." Further review of the report failed to indicate an investigation was conducted in regards to the injury of unknown origin.</p> <p>An interview with the Qualified Intellectual Disabilities Professional Designee (QIDPD) was conducted on 4/18/14 at 12:40 P.M.. When asked if investigations were completed in regards to the injuries of unknown origin and allegations of neglect, the QIDPD indicated she was not sure. The QIDPD indicated she recently was assigned this group home from a prior QIDP. When asked if there was written documentation to indicate investigations were completed, the QIDP indicated she was not sure because she was recently assigned to this home.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview, for 2 of 3 sampled clients and 3</p>	W000157	W157 – On 4/30/14 the new GH nurse and SGL director	05/12/2014

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  04/18/2014	
NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383			
(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>additional clients (clients #1, #3, #4, #5 and #6), the facility failed to take sufficient corrective measures in regard to preventing medication errors.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted on 4/14/14 at 12:40 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports indicated:</p> <p>-BDDS report dated 4/2/13: "While staff was passing P.M. medication on 4/2/14 she noticed that [client #4] had not received his Dantrolene (muscle spasms) that morning at 7:00 A.M.."</p> <p>-BDDS report dated 4/27/13: "[Client #5] was not given his 4 P.M. medication on 4/27/13. [Client #5] was not given his Omeprazole 20 mg (heartburn) (milligram) and Divalproex 250 mg (bipolar). Pills was (sic) still in the bubble pack and no signature was on the med sheets. The error was discovered on 4/28/13 at 4:00 P.M.."</p> <p>-BDDS report dated 5/4/13: "[Client #6] was prescribed Ciprofloxacin Solution 0.3% ear drops to be given 4 drops in both ears twice daily for 10 days starting 4/29/13 through 5/8/13, for ear infection</p>		<p>cross-referenced all MAR's with medications and contacted the pharmacy for verification of medication times, dose, route, and participant. During the review, the GH nurse and SGL director ensured all solutions were available for required dosages to be dispensed. On 5/7/14, the GH nurse retrained all staff on proper dispensing of medications, 3 checks prior to dispensing medications, and 6 rights of medication administration. To ensure further compliance staff is trained on Med Core A&amp; B and trained on medication administration annually. The QDDP will conduct random monthly home visits and monitor staff during medication administration. The GH nurse will conduct a 1:1 med pass with each med passer to ensure the medication administration policy is being followed and all staff are competent in medication administration. If it is determined at anytime that the staff fails to follow the policy and procedure competency the staff will be immediately suspended from administering medication. Along with being suspended the staff will be required to retake Med Core A&amp; B within 30 days by a certified nurse instructor.</p>				

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  04/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383
---	--

(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>(sic). On 5/4/13, at 8:00 P.M., [client #6] received 4 drops in his right ear, but there was only enough solution to administer 2 drops in his left ear....He will be missing both 7:00 A.M. and 8:00 P.M. doses on Sunday, May 5, as well as the 7:00 A.M. dose on Monday the 6th."</p> <p>-BDDS report dated 8/28/13: "[Client #4] left with his parents for dinner before he was given his 4:00 P.M. and 5:00 P.M. meds. The meds are Diazepam 2 mg (anxiety) at 4:00 P.M., Dantrolene 25 mg (muscle spasms) at 5:00 P.M., Baclofen 20 mg (muscle relaxer) at 5:00 P.M. and Nystop powder (fungal infections) at 5:00 P.M.."</p> <p>-BDDS report dated 8/9/13 indicated: "Staff gave [client #5] his Calcium pill (supplement) at 2:00 P.M. but was only supposed to be given at 11:00 A.M.."</p> <p>-BDDS report dated 9/18/13: "[Client #4] did not get his 4:00 P.M. meds on Monday, September 18th, 2013. His meds were Diazepam (anxiety) Tablet 2 mg, Dantrolene Capsule (muscle spasms) 25 mg and Baclofen (muscle relaxer) Tablet 20 mg."</p> <p>-BDDS report dated 12/1/13 involving client #4 indicated: "Notified that a discontinued medication Risperdal had</p>			

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  04/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383
---	--

(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>been given for days 1-5 in January 2014 by staff supervisor of group home. On 1/5/14; upon further investigation medication administration records have a discontinue order properly displayed on the appropriate date in November; the discontinue order was not carried out and written on the December medication administration record and pharmacy never received doctor's discontinue order for the medication; RESULT December medication administration record listed Risperdal as current daily med = staff did not correct order from November = participant received Risperdal for 35 days after date doctor ordered it to be discontinued."</p> <p>-BDDS report dated 1/6/14: "[Client #5] was given Risperidone tablet 1 mg for days one through five of this month. This medicine was previously discontinued. Nursing was notified and we are to discontinue the medication."</p> <p>-BDDS report dated 1/8/14: "[Client #3] did not have enough Generlac Solution (constipation) to complete his required dosage this morning at 7:00 A.M.."</p> <p>-BDDS report dated 2/1/14: "I received a call from the Group Home Manager and she was asking about medication for [client #5] that he took that morning in</p>			

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  04/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383
---	--

(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>error as it was previously discontinued. She said that it was the Linzess. I said that is correct he should no longer be taking that medication. I then contacted the staff at the group home and asked how many days he had taken the medication and he had received it days 1-4 February. I directed staff to discontinue the medication and mark it in the book."</p> <p>-BDDS report dated 3/17/14: "[Staff #13 name] was notified by [Staff #12] that [client #3] did not receive his 7:00 A.M. doses of Generlac on 3/16 and 3/17."</p> <p>-BDDS report dated 3/21/14: "[Client #5] started a new medication yesterday 3/20/14 (Methylprednisolone 4 mg) (inflammation). He did not receive his 6:00 P.M. and 8:00 P.M. on 3/21/14 and his 6:00 A.M. and 12:00 P.M. on 3/22/14."</p> <p>Further review of the reports failed to indicate the facility took effective/sufficient corrective action to prevent recurrence.</p> <p>An interview with the Qualified Intellectual Disabilities Professional Designee (QIDPD) was conducted on 4/18/14 at 12:40 P.M.. The QIDPD indicated staff are trained on</p>			

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  04/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383
---	--

(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
W000218	<p>administering medications prior to working at the group home. The QIDPD indicated staff are retrained when incidents occur and sometimes receive disciplinary action. No documentation was submitted for review to indicate the facility took sufficient corrective action to prevent recurrence of medication errors.</p> <p>9-3-2(a)</p> <p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include sensorimotor development. Based on observation, record review and interview for 1 of 3 sampled clients (client #1), the facility failed to obtain a sensorimotor assessment in regards to the client's unsteady gait and documented falls.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 4/10/14 from 3:30 P.M. until 4:40 P.M.. During the entire observation period client #1 walked around his home with an unsteady gait, dragging his feet and wobbling from side</p>	W000218	<p>W218 – Client 1 had a PT evaluation completed on 5/7/14. To ensure compliance IDT documentation now includes a section to discuss comprehensive functional assessments and determine what is needed. The IDT will discuss health and safety ensuring appropriate action is taken. If more testing, documentation, or evaluating is necessary the QDDP will make certain it is implemented for the protection of each participant. To ensure further compliance the monthly summaries will be reviewed by the SGL director.</p>	05/12/2014

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  04/18/2014	
NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383			
(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>to side.</p> <p>A morning observation was conducted at the group home on 4/11/14 from 6:00 A.M. until 7:45 A.M.. During the entire observation period client #1 walked around his home with an unsteady gait, dragging his feet and wobbling from side to side.</p> <p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS) and Internal Incident Reports (IRs) was conducted on 4/14/14 at 12:40 P.M.. Review of the reports indicated:</p> <p>-BDDS report dated 5/11/13 indicated: "At 7:45 A.M. on 5/11/13, [client #1] fell and landed on his left side, resulting in redness on his left elbow. There was nothing blocking his walking path, nor anything that could be determined to have caused the fall. [Client #1] was in an excited mood all day and had not slept much during the previous night. He was not acting tired at all neither prior to or following the fall. QDDP (Qualified developmental Disabilities Professional), manager and parents were notified of the fall, a fall assessment, incident report, and BDDS report were completed. The fall was documented in the health notes and the injury in the body check."</p>						

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  04/18/2014
NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383		
(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>-IR dated 1/13/14 indicated: "While getting off the van, [client #1] walked down the steps of the van, after off the van [client #1] stood for 30 seconds, and leaned over and fell. I was holding his belt and his coat still from walking from down the steps, which allowed me to help him to the ground. [Client #1] didn't seem to be hurt, and a body check was performed and no marks were to be found from the fall."</p> <p>A review of client #1's record was conducted on 4/14/14 at 3:30 P.M.. Review of the record did not indicate a sensorimotor assessment.</p> <p>An interview with the Qualified Intellectual Disabilities Professional Designee (QIDPD) was conducted on 4/18/14 at 12:40 P.M.. The QIDPD indicated client #1 walked with an unsteady gait. The QIDPD indicated there was no documentation to indicate client #1 had a sensorimotor assessment completed.</p> <p>9-3-4(a)</p>				

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  04/18/2014
NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383		
(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	
W000220	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include speech and language development.</p> <p>Based on observation, record review and interview, the facility failed for 1 of 3 sampled clients (client #2) to ensure a speech assessment was completed for a client who needed assistance with communication skills.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 4/11/14 from 6:00 A.M. until 7:45 A.M.. During the entire observation client #2 was observed to require assistance with communication in that the client gasped for air as he tried to speak and could not speak clearly.</p> <p>A review of client #2's record was conducted on 4/14/14 at 3:00 P.M.. Client #2's record indicated: "Medical Appointment Form...Date of appointment: 5/13/14 (sic)...Speech Therapist...Speech Evaluation...Pt (patient) presents for initial speech evaluation. Staff to follow up with patients mother for further history information. Patient to be rescheduled after OT/PT (Occupational Therapy/Physical Therapy) evaluations</p>	W000220	W220 – Client # 2 had speech evaluation on 5/6/14. To ensure compliance IDT documentation now includes a section to discuss comprehensive functional assessments and determine what is needed. The IDT will discuss health and safety ensuring appropriate action is taken. If more testing, documentation, or evaluating is necessary the QDDP will make certain it is implemented for the protection of each participant. To ensure further compliance the monthly summaries will be reviewed by the SGL director.	05/12/2014	

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  04/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383
---	--

(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
W000322	<p>for further sessions." Further review did not indicate client #2 had a speech evaluation/assessment completed as recommended on 5/13/13.</p> <p>An interview with the Qualified Intellectual Disabilities Professional Designee (QIDPD) was conducted on 4/18/14 at 12:40 P.M.. When asked if client #2 had a speech evaluation/assessment completed, the QIDPD indicated there was no documentation to indicate one had been completed.</p> <p>9-3-4(a)</p> <p>483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care.</p> <p>Based on record review and interview, the facility failed for 1 of 3 sampled clients (client #3) to provide an annual physical.</p> <p>Findings include:</p> <p>A review of client #3's record was conducted on 4/14/14 at 4:00 P.M.. Client #3's record indicated a most current annual physical dated 3/21/13.</p>	W000322	W322 - Client # 3 had annual completed on 3/25/14. The GH was in compliance for this citation.	05/12/2014

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  04/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383
---	--

(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
W000331	<p>Client #3's record did not contain evidence he had an annual physical.</p> <p>An interview with the Qualified Intellectual Disabilities Designee (QIDPD) was conducted on 4/18/14 at 12:40 P.M.. The QIDPD indicated there was no evidence of an current annual physical.</p> <p>9-3-6(a)</p> <p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview, the facility failed for 2 of 3 sampled clients and 2 additional clients (clients #1, #3, #4 and #5), by not ensuring the facility's nursing services reported the pharmacist's recommendations to the physician and Interdisciplinary Team (IDT) and provided nursing services (assessment of injuries).</p> <p>Findings include:</p> <p>1. A review of the facility's pharmacy reviews was conducted on 4/16/14 at 1:30 P.M.. The consulting pharmacist indicated:</p>	W000331	<p>W331 – Part 1 – The lead nurse and/or designee has faxed all recommendations by the pharmacist to the physician with a request for a review and signature. The lead nurse and/or designee will review the physician orders and make appropriate changes to medication administration records. Quarterly, the Lead nurse and/or designee will complete file audits to ensure this process is continued and the agency remains in compliance. Client #4 stopped taking Diazepam on 10/22/13. Part 2 – The GH nurse will review med sheets each month while completing house visits to ensure proper diagnosis is completed.</p>	05/12/2014

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  04/18/2014
NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383		
(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>Consultation Report for Recommendation Created between 4/1/13 and 5/2/13:</p> <p>"This patient is no longer seeing [Physician name]. Please evaluate the need/necessity of [client #1]'s PRN (when needed) medication regimen and adjust if appropriate (tylenol, ibuprofen, lactulose, benadryl, rulox)." Further review failed to indicate the facility's nursing staff reported the pharmacist's recommendations to the IDT and physician.</p> <p>"After reviewing [client #3]'s med sheets this quarter. I noticed that he is currently on four different medications for hypertension. His daily blood pressure readings (for the month of March) indicate that his hypertension is currently controlled. If at any point, his hypertension becomes uncontrolled/unstable, then please consider the addition of spironolactone to his medication regimen. This medication is the choice for patients who are taking &gt; 4." Further review failed to indicate the facility's nursing staff reported the pharmacist's recommendations to the IDT and physician.</p> <p>Consultation Report for</p>		<p>The QDDP will also check during their house visits and report any discrepancies to the nursing dept. Client #3 PRN was re-evaluated by his current physician at his annual on 3/25/14. Part 3 – The Social Services Senior Director has informed the nursing department that starting immediately the nurse will be informed of documented injuries by the QDDP and/or Manager. The nurse will assess the injury and determine the medical care plan for the participant and document the findings. To ensure further compliance, the QDDP and/or Manager will notify nursing through review of incident reports and BDDS reportable incidents. The nurse will examine the area of injury and document on the report the completed assessment, findings, any follow-up and/or recommendations. The nurse will notify the GH Manager/Assistant Manager will inform staff of the nursing recommendations and follow-up as needed on the individual.</p>		

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  04/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383
---	--

(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>Recommendation Created between 7/1/13 and 8/14/13:</p> <p>"After reviewing [client #3]'s med sheets for the last quarter. I noticed that a diagnosis for proctozone (PRN) (hemorrhoids) was missing from the med sheets. Please provide a diagnosis that supports the use of proctozone so that it may be included in the medical record." Further review failed to indicate the facility's nursing staff reported the pharmacist's recommendations to the IDT and physician.</p> <p>Consultation Report for Recommendation Created between 10/22/13 and 11/25/13:</p> <p>"Currently [client #1] has several PRN medications listed in his medical record prescribed by [Physician name]. Please consult with his current primary physician to determine the necessity/need of these medications." Further review failed to indicate the facility's nursing staff reported the pharmacist's recommendations to the IDT and physician.</p> <p>"[Client #3]...Pharmacological and toxic effects may be increased with concurrent administration of metoprolol and Verapamil. Hypotension, bradycardia,</p>			

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  04/18/2014	
NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383			
(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>cardiac failure and life threatening cardiac conduction abnormalities may result. Please adjust current therapy if necessary." Further review failed to indicate the facility's nursing staff reported the pharmacist's recommendations to the IDT and physician.</p> <p>"[Client #4] has been taking diazepam for the past 6 months without dosage reduction. Please evaluate and consider reducing dose if appropriate." Further review failed to indicate the facility's nursing staff reported the pharmacist's recommendations to the IDT and physician.</p> <p>"After reviewing [client #5]'s med sheets for the last quarter, I noticed a diagnosis was missing/incomplete for several medications. Please provide a diagnosis that supports the use of the following medications so that they may be included in the medical record...Omeprazole, Diastat, folic acid, sertraline, topiramate, divalproex, Banzel and levothyroxine." Further review failed to indicate the facility's nursing staff reported the pharmacist's recommendations to the IDT and physician.</p> <p>"After reviewing [client #4]'s med sheets for the last quarter, I noticed that a</p>						

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  04/18/2014
NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383		
(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>diagnosis was missing/incomplete for a few medications. Please provide a diagnosis that supports the use of the following medications so that they may be included in the medical record. Metoprolol and Lisinopril." Further review failed to indicate the facility's nursing staff reported the pharmacist's recommendations to the IDT and physician.</p> <p>Consultation Report for Recommendation Created between 1/30/14 and 1/31/14::</p> <p>"[Client #3] is no longer seeing [Physician name]. Please evaluate the need/necessity of [client #3]'s PRN medication regimen and adjust if appropriate (tums, benadryl, rulox, ibuprofen, tylenol, milk of magnesia and q-tussin). Pharmacology and toxic effects may be increased with concurrent administration of metoprolol and Verapamil. Hypotension, bradycardia, cardiac failure and life threatening cardiac abnormalities may result. Please adjust current therapy if necessary."</p> <p>2. A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports and Incident Reports (IR) was conducted on 4/14/14 at 12:40 P.M.. Review of the records indicated:</p>				

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  04/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383
---	--

(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>-BDDS report dated 11/3/13 involving client #5 indicated: "On 11/2/13 [client #5] fell down in the bathroom and had a seizure an hour and a half later. He had no marks or bruises but he was walking very unsteady (sic) and seemed to be in pain anytime he moved or got up. The group home contacted the nurse and she instructed staff to give him 2 ibuprofen every 4 hours. Today 11/3/13 staff noticed [client #5] was walking very unsteady (sic) seemed to be in pain when he gets up or walks around and talking differently. Staff took [client #5] to the ER (Emergency Room) this afternoon at 12:00 P.M.. ER took his blood, did a urine test, took x-rays and did a CAT scan. Everything came back clear except for the X-rays, they showed that [client #5] had a slight case of pneumonia and his lungs were bruised." There was no documentation to indicate the facility's nursing staff assessed client #5 after the documented fall.</p> <p>-BDDS report dated 11/11/13 involving client #3 indicated: "Monday morning at 10:00 A.M. staff from [Day program] called and said [client #3]'s right ring finger nail was infected and he needed to go to Urgent care as soon as he got home...The doctor drained it and prescribed him antibiotics, he also said</p>			

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  04/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383
---	--

(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>soak the finger in warm water for 20 minutes 3 to 4 times a day." There was no documentation to indicate the facility's nursing staff assessed client #3's finger.</p> <p>-BDDS report dated 12/1/13 involving client #4 indicated: "Notified that a discontinued medication Risperdal had been given for days 1-5 in January 2014 by staff supervisor of group home. On 1/5/14; upon further investigation medication administration records have a discontinue order properly displayed on the appropriate date in November; the discontinue order was not carried out and written on the December medication administration record and pharmacy never received doctor's discontinue order for the medication; RESULT December medication administration record listed Risperdal as current daily med = staff did not correct order from November= participant received Risperdal for 35 days after date doctor ordered it to be discontinued."</p> <p>An interview with the Qualified Intellectual Disabilities Professional Designee (QIDPD) was conducted on 4/18/14 at 12:40 P.M.. The QIDPD indicated the facility's nursing staff were responsible for reviewing the pharmacist's recommendations and reporting the recommendations to the</p>			

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  04/18/2014	
NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383			
(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			
W000336	<p>IDT. The QIDPD indicated the pharmacist's recommendations were not reported to the prescribing physician or the IDT by the former nurse.</p> <p>9-3-6(a)</p> <p>483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. Based on record review and interview for 3 of 3 sampled clients (clients #1, #2 and #3), the facility's nursing services failed to conduct quarterly nursing assessments of the clients' health status and medical needs.</p> <p>Findings include:</p> <p>A review of client #1's record was conducted on 4/14/14 at 3:30 P.M.. Client #1's record indicated a nursing quarterly was completed on 2/17/14. Client #1's most current annual physical was dated 3/11/14. Client #1's 4/14</p>	W000336	W336- The nursing department has completed quarterly nursing reviews on each participant. To ensure further compliance, the quarterlies will be checked by the Social Services Senior Director upon completion at the end of each quarter. File audits will be completed on a random sample of files to ensure nursing forms are completed and in the participant file by Lead nurse at least twice a year.	05/12/2014			

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  04/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383
---	--

(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>physician orders indicated client #1 received routine medications. There was no documentation to indicate nursing quarterlies were completed for the quarters of 4/13, 7/13 and 10/13.</p> <p>A review of client #2's record was conducted on 4/14/14 at 3:00 P.M.. Client #2's record indicated a nursing quarterly was completed on 2/18/14. Client #2's most current annual physical was dated 3/26/14. Client #2's 4/14 physician orders indicated client #2 received routine medications. There was no documentation to indicate nursing quarterlies were completed for the quarters of 4/13, 7/13 and 10/13.</p> <p>A review of client #3's record was conducted on 4/14/14 at 4:00 P.M.. Client #3's record indicated a nursing quarterly was completed on 2/17/14. Client #3's most current annual physical was dated 3/21/13. Client #3's 4/14 physician orders indicated client #3 received routine medications. There was no documentation to indicate nursing quarterlies were completed for the quarters of 4/13, 7/13 and 10/13.</p> <p>An interview with the Qualified Intellectual Disabilities Professional Designee (QIDPD) was conducted on 4/18/14 at 12:40 P.M.. The QIDPD</p>			

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  04/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383
---	--

(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
W000368	<p>indicated nursing quarterlies are to be completed quarterly. The QIDPD further indicated the former nurse failed to conduct nursing quarterlies.</p> <p>9-3-6(a)</p> <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 3 sampled clients and 3 additional clients (clients #3, #4, #5 and #6) were administered in compliance with the physician's orders.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted on 4/14/14 at 12:40 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports indicated: -BDDS report dated 4/2/13: "While staff was passing P.M. medication on 4/2/14 she noticed that [client #4] had not received his Dantrolene (muscle spasms) that morning at 7:00 A.M.."</p>	W000368	W368 – See Plan of correction for W157	05/12/2014

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  04/18/2014	
NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383			
(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>-BDDS report dated 4/27/13: "[Client #5] was not given his 4 P.M. medication on 4/27/13. [Client #5] was not given his Omeprazole 20 mg (heartburn) (milligram) and Divalproex 250 mg (bipolar). Pills was (sic) still in the bubble pack and no signature was on the med sheets. The error was discovered on 4/28/13 at 4:00 P.M.."</p> <p>-BDDS report dated 5/4/13: "[Client #6] was prescribed Ciprofloxacin Solution 0.3% ear drops to be given 4 drops in both ears twice daily for 10 days starting 4/29/13 through 5/8/13, for ear infection (sic). On 5/4/13, at 8:00 P.M., [client #6] received 4 drops in his right ear, but there was only enough solution to administer 2 drops in his left ear....He will be missing both 7:00 A.M. and 8:00 P.M. doses on Sunday, May 5, as well as the 7:00 A.M. dose on Monday the 6th."</p> <p>-BDDS report dated 8/28/13: "[Client #4] left with his parents for dinner before he was given his 4:00 P.M. and 5:00 P.M. meds. The meds are Diazepam 2 mg (anxiety) at 4:00 P.M., Dantrolene 25 mg (muscle spasms) at 5:00 P.M., Baclofen 20 mg (muscle relaxer) at 5:00 P.M. and Nystop powder (fungal infections) at 5:00 P.M.."</p> <p>-BDDS report dated 8/9/13 indicated:</p>						

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  04/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383
---	--

(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>"Staff gave [client #5] his Calcium pill (supplement) at 2:00 P.M. but was only supposed to be given at 11:00 A.M.."</p> <p>-BDDS report dated 9/18/13: "[Client #4] did not get his 4:00 P.M. meds on Monday, September 18th, 2013. His meds were Diazepam (anxiety) Tablet 2 mg, Dantrolene Capsule (muscle spasms) 25 mg and Baclofen (muscle relaxer) Tablet 20 mg."</p> <p>-BDDS report dated 12/1/13 involving client #4 indicated: "Notified that a discontinued medication Risperdal had been given for days 1-5 in January 2014 by staff supervisor of group home. On 1/5/14; upon further investigation medication administration records have a discontinue order properly displayed on the appropriate date in November; the discontinue order was not carried out and written on the December medication administration record and pharmacy never received doctor's discontinue order for the medication; RESULT December medication administration record listed Risperdal as current daily med = staff did not correct order from November= participant received Risperdal for 35 days after date doctor ordered it to be discontinued."</p> <p>-BDDS report dated 1/6/14: "[Client #5]</p>			

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  04/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383
---	--

(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>was given Risperidone tablet 1 mg for days one through five of this month. This medicine was previously discontinued. Nursing was notified and we are to discontinue the medication."</p> <p>-BDDS report dated 1/8/14: "[Client #3] did not have enough Generlac Solution (constipation) to complete his required dosage this morning at 7:00 A.M.."</p> <p>-BDDS report dated 2/1/14: "I received a call from the Group Home Manager and she was asking about medication for [client #5] that he took that morning in error as it was previously discontinued. She said that it was the Linzess. I said that is correct he should no longer be taking that medication. I then contacted the staff at the group home and asked how many days he had taken the medication and he had received it days 1-4 February. I directed staff to discontinue the medication and mark it in the book."</p> <p>-BDDS report dated 3/17/14: "[Staff #13 name] was notified by [Staff #12] that [client #3] did not receive his 7:00 A.M. doses of Generlac on 3/16 and 3/17."</p> <p>-BDDS report dated 3/21/14: "[Client #5] started a new medication yesterday 3/20/14 (Methylprednisolone 4 mg)</p>			

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  04/18/2014	
NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383			
(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>(inflammation). He did not receive his 6:00 P.M. and 8:00 P.M. on 3/21/14 and his 6:00 A.M. and 12:00 P.M. on 3/22/14."</p> <p>A review of the facility's "Universal Policies and Procedures-Medication Administration" dated 8/8/13 was conducted on 4/15/14 at 11:15 A.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 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>						

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  04/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383
---	--

(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>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 Registered Nurse (RN) and the Qualified Intellectual Disabilities Professional Designee (QIDP) was conducted on 4/18/14 at 12:40 P.M.. The RN and QIDPD indicated staff should have administered the clients' medications as ordered. The RN and QIDPD further indicated staff should have followed the facility's medication administration policy.</p> <p>9-3-6(a)</p>			

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  04/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383
---	--

(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
W000369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review and interview, the facility failed for 1 of 2 clients observed during the morning medication administration (client #5) to ensure staff administered 1 of 9 of the client's medications, as ordered without error.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 4/11/14 from 6:00 A.M. until 7:45 A.M.. At 6:30 A.M., client #5 ate his breakfast which consisted of a bowl of oatmeal. At 6:45 A.M., Direct Support Professional (DSP) # 7 began administering client #5's prescribed oral medications. DSP #7 took a packet out of client #5's medications, looked at the packet, and stated "This should have been given at 5 A.M.." DSP #7 the popped the medication out of the packet into a clear plastic medication cup and administered the medication to client #5. Review of</p>	W000369	W369 - See Plan of correction for W157	05/12/2014

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  04/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383
---	--

(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
--------------------	--	---------------	---	----------------------

W000436	<p>the medication packet and Medication Administration Record (MAR) dated 4/1/14 to 4/30/14 indicated: "Levothyroxin Tablet 88 mcg (microgram)...1 tablet by mouth every morning on an empty stomach...5:00 A.M....Thyroid." Client #5 did not receive his medication at 5:00 A.M. and did not take his medication on an empty stomach as ordered.</p> <p>An interview with the Registered Nurse (RN) was conducted on 4/18/14 at 10:11 A.M.. The RN indicated client #5's medications should have been administered as directed on the label and MAR.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p>			
---------	---	--	--	--

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  04/18/2014
NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383		
(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 observation, record review and interview, the facility failed to assure the repair of adaptive equipment for 1 of 3 sampled clients (client #2) who used a wheelchair for mobility.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group on 4/11/14 from 6:00 A.M. until 7:45 A.M.. During the entire observation client #2 sat in his personalized wheelchair. Client #2's right arm rest was observed to have silver duct tape wrapped around it. When asked what was wrong with his wheelchair, client #2 stated "Broken." When asked if his wheelchair had been broken over a month, client #2 stated "Yes."</p> <p>A review of client #2's record was conducted on 4/14/14 at 2:30 P.M.. Review of client #2's record indicated he used a wheelchair at all times for mobility. The record failed to indicate client #2's wheelchair had repairs completed to his wheelchair.</p> <p>An interview with the Qualified Intellectual Disabilities Professional Designee (QIDPD) was conducted on 4/18/14 at 12:40 P.M.. The QIDPD indicated she did not know why client</p>	W000436	W436 – There were no other participants affected by the deficient practice. All other adaptive devices were checked at that moment and they will be routinely checked monthly by the QDDP to ensure further compliance.	05/12/2014	

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  04/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 355 SHEFFIELD VALPARAISO, IN 46383
---	--

(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>#2's wheelchair had duct tape around the arm rest. When asked when the wheelchair would be repaired, the QIDPD indicated the facility was going to make an appointment to have client #2's wheelchair checked and repaired.</p> <p>9-3-7(a)</p>			