

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G726	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/29/2016
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NAME OF PROVIDER OR SUPPLIER OPPORTUNITY ENTERPRISES	STREET ADDRESS, CITY, STATE, ZIP CODE 501 ALBERT ST VALPARAISO, IN 46383
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W 0000 Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: 2/22, 2/23 and 2/29/16.</p> <p>Facility number: 004789 Provider number: 15G726 AIM number: 200827230</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 3/4/16.</p>	W 0000		
W 0140 Bldg. 00	<p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on interview and record review for 1 of 3 sampled clients (#3), the facility failed to maintain a complete accounting of the client's funds when given to the client's sister to spend/utilize.</p> <p>Findings include:</p> <p>Client #3's financial records were reviewed on 2/23/16 at 2:10 PM. Client #3's December 2015 Banking Transactions records for the client's</p>	W 0140	In this circumstance, the client's family requested money,for the purchase of an airline ticket. A receipt has been obtained, from the client's family, and will be kept with the client's financial records. An audit has been conducted, to ensure that no other clients have been affected by this deficient practice; findings conclude that all other clients have accurate receipts, accounting for all purchases they have made. To ensure this deficient practice does not reoccur, the agency has	03/18/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 0149 Bldg. 00	<p>checking account indicated \$300.00 was withdrawn on 12/18/15 from the client's account. The facility did not have any receipts for the \$300.00.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 2/23/16 at 2:50 PM indicated she could not locate the receipts from the \$300.00. The QIDP indicated the money was given to client #3's sister. The QIDP indicated client #3's sister would normally turn in the receipts. The QIDP indicated she thought the money may have been used to purchase client #3 a plane ticket to go visit a different sister, but the QIDP was not for sure.</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 interview and record review for 2 of 3 sampled clients (#1 and #2) and for 1 additional client (#5), the facility failed to develop a written policy and procedure in regard to how the facility would address client to client aggression/abuse incidents.</p> <p>Findings include:</p>			W 0149	<p>developed a form, which will be signed, prior to the release of client funds, by the family or guardian. The form is designed to document the reason for the request of money and the intention of how the money will be spent. The form will also give notice, to the guardian or family member, that receipts are required, for all purchases, to be kept with the client's financial records. To ensure this form is implemented correctly, a quality assurance audit, of client receipts, will occur quarterly, by the Group Home Director or designee. The audit will examine all client financial records and seek to find that each client purchase has a receipt and signed form of intention.</p> <p>To identify other clients that may have been affected by this deficient practice, an audit has been completed on all incident reports of client to client aggression. The audit found that no other clients, in this group home, were affected by this deficient practice. As part of a policy change (See Attached), the agency will now investigate all incidents of client to client</p>		03/07/2016

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	<p>The facility's reportable incident reports, Generated Event Reports (GERs) and/or investigations were reviewed on 2/22/16 at 2:40 PM. The facility's GERs indicated the following (not all inclusive):</p> <p>-12/28/15 "[Client #1] tried to socialize with a peer when he began to pull her hair. staff (sic) prompted him to stop and he was moved to another area way from [client #1]." The GER indicated client #1 was not injured.</p> <p>-12/7/15 "[Client #5] took her bedtime meds (medications) and prepared to brush her teeth. her hygiene goal is to brush for a full two minutes, and when staff asked her to brush for the required time, she began pacing...[Client #5] rushed out of the office with her hand raised and headed towards a peer's room who had their door open. Staff redirected [client #5] away from her peer's room and back to the office, but [client #5] instead made a beeline into the living room where her peers were watching a movie. [Client #5] pushed her way past the staff trying to calm her down and smacked her peer, in the forehead..." The GER indicated facility staff followed client #5's Behavior Support Plan (BSP). The GER indicated "...QDDP (Qualified</p>		aggression, regardless of injury. To assist and formalize investigations, a standardized form (see attached) has been developed and implemented, as of 3.7.16.				

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	<p>Developmental Disabilities Professional) spoke with the GHM (Group Home Manager) [staff #1] who looked at [client #5's] birth control and noticed she was about to start her menstrual cycle. Lately right before [client #5's] menstrual cycle she get's (sic) a little agitated and sometime gets physical...."</p> <p>-10/28/15 "[Client #2] and a peer were threatening each other with closed fists for about 10 minutes and staff was attempting to break up the frustration and get them involved in the activity. When her peer acted more calm staff brought the group back together to rejoin an activity and this is when [client #2] showed her peer her middle finger. This caused her peer to become aggressive to her and started yelling and threatening more, and she also hit her back and the yelling increased. [Client #2] then was removed from the room by another staff to go for a walk. When the group came into the hallway her peer once again hit her, and [client #2] hit her back." The GER indicated there were no injuries. The facility's 9/15 to 2/16 reportable incident reports indicated the facility did not conduct an investigation in regard to the above mentioned client to client aggression/abuse incidents.</p> <p>The facility's policy and procedures were</p>			

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	<p>reviewed on 2/22/16 at 2:43 PM. The facility's 6/2/15 policy entitled Opportunity Enterprises, Inc. (Incorporated) Universal Policies and Procedures Programming and Services Policy #6012-Abuse and Neglect indicated the facility's 6/2/15 policy did not indicate how the facility would conduct investigations in regard to client to client aggression/abuse incidents.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) and the Director on 2/23/16 at 3:12 PM indicated the facility used to report all client to client incidents of aggression to the state and the facility used to conduct investigations of all client to client incidents. The QIDP indicated the state agency had asked them to report client to client incidents which resulted in injury/injuries to clients. The QIDP indicated the facility did not conduct investigations in regard to the above mentioned incidents as the clients had a formal behavior plan for physical aggression. The QIDP and the Director indicated the facility's policy and/or procedure did not specifically indicate how the facility would investigate client to client aggression/abuse incidents.</p> <p>9-3-2(a)</p>			

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W 0154 Bldg. 00	<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 interview and record review for 3 of 3 allegations of abuse and/or neglect reviewed, the facility failed to conduct investigations in regard to incidents of allegations of client to client abuse/aggression for clients #1, #2 and #5.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, Generated Event Reports (GERs) and/or investigations were reviewed on 2/22/16 at 2:40 PM. The facility's GERs indicated the following (not all inclusive):</p> <p>-12/28/15 "[Client #1] tried to socialize with a peer when he began to pull her hair. staff (sic) prompted him to stop and he was moved to another area way from [client #1]." The GER indicated client #1 was not injured.</p> <p>-12/7/15 "[Client #5] took her bedtime meds (medications) and prepared to brush her teeth. her hygiene goal is to brush for a full two minutes, and when staff asked her to brush for the required</p>	W 0154	To identify other clients that may have been affected by this deficient practice,an audit has been completed on all incident reports of client to client aggression. The audit found that no other clients, in this group home, were affected by this deficient practice. As part of a systematic change and policy change, the agency will now investigate all incidents of client to client aggression, regardless of injury. To assist and formalize investigations, a standardized form (see attached) has been developed and implemented, as of 3.7.16.	03/07/2016

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	<p>time, she began pacing...[Client #5] rushed out of the office with her hand raised and headed towards a peer's room who had their door open. Staff redirected [client #5] away from her peer's room and back to the office, but [client #5] instead made a beeline into the living room where her peers were watching a movie. [Client #5] pushed her way past the staff trying to calm her down and smacked her peer, in the forehead..." The GER indicated facility staff followed client #5's Behavior Support Plan (BSP). The GER indicated "...QDDP (Qualified Developmental Disabilities Professional) spoke with the GHM (Group Home Manager) [staff #1] who looked at [client #5's] birth control and noticed she was about to start her menstrual cycle. Lately right before [client #5's] menstrual cycle she get's (sic) a little agitated and sometime gets physical..."</p> <p>-10/28/15 "[Client #2] and a peer were threatening each other with closed fists for about 10 minutes and staff was attempting to break up the frustration and get them involved in the activity. When her peer acted more calm staff brought the group back together to rejoin an activity and this is when [client #2] showed her peer her middle finger. This caused her peer to become aggressive to her and started yelling and threatening</p>			

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W 0262 Bldg. 00	<p>more, and she also hit her back and the yelling increased. [Client #2] then was removed from the room by another staff to go for a walk. When the group came into the hallway her peer once again hit her, and [client #2] hit her back." The GER indicated there were no injuries. The facility's 9/15 to 2/16 reportable incident reports indicated the facility did not conduct an investigation in regard to the above mentioned client to client aggression/abuse incidents.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) and the Director on 2/23/16 at 3:12 PM indicated the facility used to conduct investigations of all client to client incidents. The QIDP indicated the facility did not conduct investigations in regard to the above mentioned client to client incidents as the clients had a formal behavior plan for physical aggression, and the clients were not injured.</p> <p>9-3-2(a)</p> <p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.</p>			

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	<p>Based on interview and record review for 2 of 2 sampled clients (#2 and #3) with restrictive programs, the facility failed to ensure its Human Rights Committee (HRC) approved and/or periodically reviewed the clients' restrictive programs.</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 2/23/16 at 1:06 PM. Client #3's 2/1/16 physician's orders indicated client #3 received Abilify 2 milligrams daily for Mood Disorder, Abilify 5 milligrams daily for Mood Disorder, Lorazepam 0.5 milligrams two times a day for Anxiety, Buspar 10 milligrams two times a day for Anxiety and Lexapro 20 milligrams daily for Depression.</p> <p>Client #3's 8/5/15 Behavior Management Plan (BMP) indicated client #3's targeted behaviors included "Inappropriate Social Behavior," "Unexplained Crying," anger outburst which included, verbal aggression, physical intimidation, physical aggression, property destruction, elopement and false accusations. Client #3's BMP indicated "...When her anger outbursts escalate to any form of physical aggression, physical intimidation or property destruction At WORK"...client #2 could be prompted to use a "Quiet Room" and/or a Relaxation Room."</p>	W 0262	<p>The attached HRC minutes and signature sheets show that each restrictive program, for Clients 2 & 3, were reviewed and approved by the HRC committee. The agency failed to have these approval letters attached to the client's restrictive program, in the client's record. On 3.7.16, the records for client 2 & 3 were updated to include their most recent HRC approvals. To ensure this deficient practice has not affected any other clients, an audit was completed wherein we examined each client's restrictive program and ensured that HRC approval letters were attached: no other clients were found to have been affected. As part of a quality assurance check, to ensure that all restrictive programs, going forward, are accompanied with an HRC approval letter, the group home director will audit client records, on a monthly basis, for a duration of 3 months, housing all documentation thereof. After three months, the director will assess whether or not the monthly audit should continue. If it is determined that more quality audits are needed, the audits will continue for another three months: if the records are found to be in full compliance the audits will cease after the first three months.</p>	03/07/2016

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	<p>Client #2's BMP also indicated physical intervention techniques could also be used with the client if she was attempting to harm herself and/or others. Client #3's record and/or 8/15/15 BMP did not indicate the facility's HRC had approved and/or reviewed the client's restrictive program.</p> <p>Client #2's record was reviewed on 2/23/16 at 10:06 AM. Client #2's 2/1/16 physician's orders indicated client #2 received Abilify for behavior.</p> <p>Client #2's 6/22/15 Behavior Support Plan (BSP) indicated client #2's diagnosis included, but was not limited to, Smith-Magenis Syndrome which was demonstrated by "Skin picking: Picking or biting finger nails until bleeding" and "Skin Rubbing: Rubbing or scratching skin until it bleeds or scabs." Client #2's BSP also indicated the syndrome included trouble sleeping at night. The BSP indicated "...[Client #2] should be encouraged to wear thin gloves when displaying skin picking or scratching to aid in the reduction and severity of injury...." Client #2's BSP indicated client #2 demonstrated the targeted behaviors pf verbal aggression, physical aggression, property destruction and non-compliance. Client #2's BSP indicated client #2's personal items (MP3</p>			
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W 0286 Bldg. 00	<p>player) could be removed/taken from the client if she refused to bathe /shower after 3 days. Client #2's BSP also indicated a "force bag" could be used to block client #2's aggression toward others, and if client #2's physical aggression continued, facility staff could utilize physical intervention techniques/restraints to prevent client #2 from harming herself and/or others. Client #2 would also not be able to call her parents in the evening if she engaged in any of her targeted behaviors. Client #2's 6/22/15 BSP and/or record did not indicate the facility's HRC approved and/or periodically reviewed the client's restrictive program.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 2/23/16 at 3:12 PM indicated client #2 and #3's restrictive program plans had been reviewed/approved by the facility's HRC committee. The QIDP indicated she would check to see the plans had been approved/reviewed. The QIDP did not provide any additional information/documentation.</p> <p>9-3-4(a)</p> <p>483.450(b)(3) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p>						

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	<p>Techniques to manage inappropriate client behavior must never be used for disciplinary purposes.</p> <p>Based on observation, interview and record review for 1 of 3 sampled clients (#2), the facility failed to ensure the client's rights in regard to taking personal items/property away from the client was not seen as disciplinary purposes as the facility failed to specifically include when, how and what could be removed when the client demonstrated specific targeted behaviors.</p> <p>Findings include:</p> <p>During the 2/23/16 observation period between 6:05 AM and 8:00 AM at the group home, at 6:10 AM, client #2 was sitting at the dining room table with her head phones and music. Staff #3 verbally reminded she needed to take a shower as client #2 had not had a shower since Sunday (2/21/16). Client #2 became upset as client #2 did not want staff #3 to assist her with her shower. Client #2 indicated she wanted a different staff person to assist her. Staff #3 told client #2 she could not choose who was to be at the group home to take a shower. Staff #4 came from the back of the house and asked what was going on. Staff #3 told staff #4 client #2 was refusing to take a shower as a particular staff person was</p>	W 0286	<p>Client(#2) has a behavior support plan that was developed by Innovations in Learning,PC, an outside behavior therapy service. The client's current plan failed to ensure that her rights, in regard to taking personal items/property away, was not seen as disciplinary purposes, dueto the fact that the plan failed to specifically include when, how and what could be removed when the client demonstrated specific targeted behaviors. To immediately correct this deficiency, a section of the client's behavior support plan, where the plan directs staff to take away personal items, has been temporary suspended, until the proper corrections can be made and the new plan implemented. On 2.29.16, the QDDP contacted Innovations in Learning, advising them of the corrections that needed to be made on the client's BSP. Innovations will ensure that if staff are to continue to take away the client's personal property, the plan will specifically include when, how and what could be removed when the client demonstrated specific targeted behaviors. This updated plan will be implemented on or before 3.30.16. Due to this plan being written by an outside company, we have not received a firm date of implementation;</p>	03/30/2016

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	<p>not at the group home. Staff #4 asked client #2 if she would be willing to "wash up." Staff #4 reminded client #2 she would not be able to go on an outing with the other ladies if she did not shower. Staff #4 also offered to let her listen to music while client #2 showered. Client #2 continued to refuse to shower. Staff #4 then told client #2 she (staff #4) would need to take her music away from her if she did not shower or wash up. Staff #4 offered to assist client #2 to shower. Client #2 refused. Staff #4 told client #2 she would take her headphones/music away. Staff #4 picked up the head phones/music and started to walk away from client #2 to the office area. Client #2 yelled out "No." Staff #4 turned around and asked her if she was ready to take her shower. Client #2 refused and stated "No." Staff #4 took client #2's personal items to the office area. Staff #4 stated to client #2 "You know the behavior plan. You know what you have to do to get it back." Client #2 did not take her shower but did allow staff #4 to assist her in combing her hair. Client #2 did not get her headphones/music back.</p> <p>Client #2's record was reviewed on 2/23/16 at 10:06 AM. Client #2's 6/22/15 Behavior Support Plan (BSP) indicated client #2 had a targeted behavior of</p>		<p>however, the behavior therapist has guaranteed that it will be before 3.30.16. To ensure this deficient practice has not affected other clients, the QDDP(s) and Group Home Director audited all client files, with behavior support plans; no other clients were found to have been affected by this practice.</p>				

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	<p>non-compliance which was defined as "Refusal to follow directions or complete required activities within 3 verbal prompts." Client #2's BSP indicated "...after 3 days of not showering, it was non-negotiable..." Client #2's BSP indicated when client #2 refused to bathe, "...Staff should present [client #2] with an option of when she can bathe. Staff may tell her, 'You can shower now or anytime within the next 2 hours.' This will help [client #2] gain independence but ensure she completes necessary hygiene tasks. Once [client #2] is compliant with bathing, staff should praise [client #2] and immediately provide access to reinforcing items of her choice..." The BSP indicated "non-negotiable" tasks included taking medication daily, daily hygiene of brushing her hair and teeth, getting ready for work, getting on the van for work, not showering after 3 days. The BSP indicated if client #2 demonstrated one of the non-negotiable behaviors, the client would need to give staff her MP3 player. Client #2's BSP indicated client #2 participated in a "Positive Reward Program at Home." The BSP indicated "a. [Client #2] will be expected to follow a daily structured routine including: Waking up on time: Completing morning and evening hygiene, including showering; Taking medications; Getting</p>			

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	<p>onto van appropriately in the morning and afternoon; Completing chores; Going to bed on time. b. [Client #2] will earn a reward from her reward menu times a day, contingent upon following her structured routine and displaying 0 (zero) target behaviors (physical aggression, verbal aggression, property destruction and non-compliance). c. [Client #2] can earn her reward in the morning before transport, in the afternoon after transport, and in the evening after dinner. d. [Client #2] will have access to the item she selects for 5 minutes. If she has chosen pop as her reward, she is to be encouraged to drink her pop during the 5 minutes...f. [Client #2] will be allowed to choose her reward, but each reward can only be chosen once each day. For example, if she chose a pop as her first reward, she could not chose it as her second reward. g. [Client #2] will not earn a reward of her choice if she displays target behaviors and does not follow her schedule within 2 verbal prompts (this includes getting on the van for transportation and showerings)..." Client #2's BSP did not indicate the specific rewards client #2 could utilize, include what particular items/activities could be restricted and/or include what client #2 had to do to get her MP3 player/other personal items back to ensure client #2 was not being disciplined</p>			
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	<p>for not being compliant.</p> <p>Interview with staff #3 on 2/23/16 at 8:02 AM indicated client #2 would refuse to bathe/shower. Staff #3 indicated they were allowed to take client #2's music and/or other items away from client #2 when she did not bathe after 2 days.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) and the Director on 2/23/16 at 3:12 PM indicated client #2's behavior plan was written by the facility's behavioral consultant. The QIDP stated client #2's BSP was "complicated" as it had a lot of components to the client's plan. The QIDP indicated facility staff were able to take the client's personal items when client #2 was non-compliant with her shower after 3 days. When asked what specific items could be taken away from client #2, the QIDP stated facility staff could take the client's "electronic items." The QIDP indicated facility staff should not take away the client's outings/activities in the community. The QIDP stated the facility's "HRC (Human Rights Committee) did not like the time limit" which was originally in the client's plan and the HRC did not approve client #2's plan. The QIDP indicated facility staff was to return client #2's personal items to the client when the client</p>						

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W 0312 Bldg. 00	<p>complied. The QIDP indicated she thought when the client was able to get her items back had been added to the behavior plan. The QIDP indicated client #2 could have her MP3 player (music) as a reward, pop, one on one time with staff and other things as a reward. When asked how the client's MP3 player could be a reward since staff could take the MP3 player away, the QIDP indicated client #2's BSP would need to be more specific. The QIDP indicated client #2's BSP would need to be more specific on when the client could lose her personal items/which ones for which behaviors so it would not look like removal of the client's items was done for disciplinary purposes.</p> <p>9-3-5(a)</p> <p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on interview and record review for 2 of 2 sampled clients (#1 and #3) on restrictive programs, the facility failed to ensure behavioral medications were a part of a client's restrictive program, and failed to ensure a client had an active</p>	W 0312	Client (#3) has a behavior support plan that was developed by Innovations in Learning, PC, an outside behavior service. The client's current plan failed to ensure an accurate list of the client's current medications. On	03/25/2016			

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	<p>treatment program for the use/need to presedate the client for dental appointments.</p> <p>Findings include:</p> <p>1. Client #3's record was reviewed on 2/23/16 at 1:06 PM. Client #3's 2/1/16 physician's orders indicated client #3 received Abilify 2 milligrams daily for Mood Disorder, Abilify 5 milligrams daily for Mood Disorder, Lorazepam 0.5 milligrams two times a day for Anxiety, Buspar 10 milligrams two times a day for Anxiety and Lexapro 20 milligrams daily for Depression.</p> <p>Client #3's 8/5/15 Behavior Management Plan (BMP) indicated client #3 received Lexapro (Depression/Anxiety), Depakote (Bipolar Disorder) and Buspar (Depression/Anxiety). Client #3's BMP indicated client #3's Abilify and Lorazepam were not part of the client's restrictive behavior plan.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) and RN (Registered Nurse) #1 on 2/23/16 at 3:12 PM indicated client #3's BMP would need to be updated to include the client's current behavioral medications.</p> <p>2. Client #1's record was reviewed on</p>		<p>3.8.16, the QDDP contacted Innovations in Learning, advising them of the corrections that needed to be made on the client's BSP. Innovations will update the client's plan to ensure the correct medications are listed; including Abilify, Lorazepam, Buspar, and Lexapro. This updated plan will be implemented on or before 3.30.16. Due to this plan being written by an outside company, we have not received a firm date of implementation; however, the behavior therapist has guaranteed that it will be before 3.30.16. To ensure this deficient practice has not affected other clients, the QDDP(s) and Group Home Director audited all client files, with behavior support plans; no other clients were found to have been affected by this practice. To ensure this deficient practice does not re-occur, the QDDP will review the client's BSP, monthly, with the Group Home Registered Nurse, to ensure accuracy of the medications listed; documentation of reviews will be housed in the QDDP's monthly IDT notes. To identify other clients that may have been affected by this deficient practice, an audit has been completed on all clients that take aprn medication for behavior; no other clients were found to have been affected. To better serve client 1, and all clients going forward, a new anxiety assessment was</p>				

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W 0331	<p>2/23/16 at 12:11 PM. Client #1's Dental Consultation Forms indicated the following (not all inclusive):</p> <p>-1/30/13 "Ultrasound with scaling under Versed sedation. Pt (patient) tolerated procedure fairly well. Continue brushing 2x (times)/day for home care."</p> <p>-9/20/15 Client #1 saw the dentist where "ultrasonic scaling" was done under oral Versed sedation.</p> <p>Client #1's 2/26/15 Individual Support Plan (ISP) and/or record indicated client #1 did not have a Behavior Support Plan (BSP) and/or an active treatment program to address the client's need/use of a pre-medication for sedation for dental appointments.</p> <p>Interview with RN #1 and the QIDP on 2/23/16 at 3:12 PM indicated client #1 required the use of pre-medication for dental appointments. The QIDP and RN #1 indicated client #1's ISP did not include an active treatment program for the use of pre-sedation medication for dental/medical appointments.</p> <p>9-3-5(a)</p> <p>483.460(c) NURSING SERVICES</p>		<p>developed and implemented by the nursing department (see attached). The assessment will help identify the source of the client's anxiety, level or severity of anxiety, and the most practical solution to help alleviate anxiety. After this assessment is completed by the nurse, the QDDP will use the information to develop an IPP, with the goal of decreasing the anxiety and therefore decreasing the need for medication. This assessment was completed, for client 1, on 3.15.16 and an IPP has been written for client 1, with the goal of decreasing client 1's sensitivity to the dentist. This IPP goal will be implemented, with staff training, on 3.25.16. To ensure this deficient practice does not re-occur, the QDDP and/or Group Home Director will review the client's records, monthly, with the Group Home Registered Nurse, to ensure that if the client uses a prn medication for behavior, an assessment and IPP goal have been completed; documentation of reviews will be housed in the QDDP's monthly IDT notes.</p>		

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Bldg. 00	<p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, interview and record review for 2 of 3 sampled clients (#2 and #4), the facility's nursing services failed to meet the nursing needs of the clients in regard to ensuring and/or monitoring the use of oxygen was part of client's risk plan, to ensure the nurse obtained clarification in regard to a client's eyeglasses, and to ensure the facility staff informed the nurse of a client's injury to her elbow.</p> <p>Findings include:</p> <p>1. During the 2/22/16 observation period between 4:29 PM and 6:30 PM and during the 2/23/16 observation period between 6:05 AM and 8:00 AM, at the group home, client #4 wore a nasal cannula with continuous oxygen at the group home.</p> <p>Client #4's record was reviewed on 2/23/16 at 2:50 PM. Client #4's 8/27/15 physician's order indicated "Pt (patient) on 3 L/min (3 liters/per minute) NC (nasal cannula) continuous oxygen."</p> <p>Client #4's 8/17/15 Medical Appointment Form indicated client #4 was originally placed on oxygen on 8/17/15 by the client's Pulmonologist. The form</p>	W 0331	<p>On 3.11.16, the agency's nursing department implemented and trained all staff on the client's updated oxygen protocol, for client 4 (see attached). To ensure this deficient practice has not affected other clients, the QDDP(s) and Group Home Director audited all client protocols; no other clients were found to have been affected. To ensure this deficient practice does not re-occur, the QDDP and/or Group Home Director will review the client's records, monthly, with the Group Home Registered Nurse, to ensure that if the client uses oxygen, an assessment and high risk protocol have been completed; documentation of reviews will be housed in the QDDP's monthly IDT notes. On 3.11.16, the nurse obtained clarification, from client 2's optometrist, in regards to the usage of eyeglasses. The optometrist stated that client 2 should wear her eyeglasses to help see at a distance and should wear them as often as possible. On 03.18.16, the QDDP and Nurse updated the client's ISP to reflect the recommendations from the Optometrist; the QDDP also developed a new IPP goal to encourage the client to wear her eyeglasses and teach the client the benefits of wearing them. This IPP goal was implemented on 3.18.16. To ensure other</p>	03/18/2016			

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	<p>indicated client #4 saw the Pulmonologist as a follow-up to the client's hospital stay in 7/15 for Pneumonia.</p> <p>Client #4's 11/25/15 Quarterly Nursing Assessment indicated "Met patient @ (at) home for assessment. Wears O2 (oxygen) 3L nasal cannula. Lungs diminished,) (zero) SOB (shortness of breath)...."</p> <p>Client #4's 2/1/16 Health Care Report indicated client #4 was assessed and "...Lungs are diminished, client wears O2 3L at all times...."</p> <p>Client #4's 2/26/15 Individual Support Plan (ISP) Medical attachment indicated client #4 had a history of being hospitalized with Pneumonia and/or other lung conditions. Client #4's 2/10/16 Pneumonia Management Protocol indicated "Participant has had recurrent pneumonia diagnosis...." The risk plan indicated facility staff were to "Observe for Pneumonia signs and symptoms: Fatigue, weakness Elevated Temperature Change in Mood, Lethargy Tachycardia (fast heart beat/high pulse) Loss of appetite Headache, chest pain, aggravated cough Cough that starts dry and progressis (sic) to productive with pink, to rust, to</p>		<p>clients were not affected by this deficient practice, the QDDP and Group Home Director audited all client ISPs; no other clients at this group home have been affected by this deficient practice. To ensure this deficient practice does not re-occur, the QDDP and/or Group Home Director will review the client's records, monthly, with the Group Home Registered Nurse, to ensure that if the client uses adaptive equipment, an assessment and IPP goal have been completed; documentation of reviews will be housed in the QDDP's monthly IDT notes. On 3.11.16, group home staff were retrained, by the Group Home Nurse, on properly reporting injuries to the QDDP and Nurse (see attached training form). To ensure other clients were not affected by this deficient practice, the QDDP and Group Home Registered Nurse audited client health files, wherein staff document skin assessments; findings concluded that all other clients had daily skin assessments completed and were not affected by this deficient practice.</p>	

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	<p>purulent sputum. CALL 911 IF THE FOLLOWING SHOULD OCCUR:</p> <ol style="list-style-type: none"> 1. Difficulty breathing 2. Skin color change (pale to a gray-blue) 3. Inability to arouse...." The 2/10/16 risk plan did not indicate client #4 was on/utilized continuous oxygen to breathe due to the client's diminished lungs. Client #4's Pneumonia risk plan also did not indicate how the client's oxygen level would be monitored to ensure the client's optimum health/oxygen level. <p>Interview with the Qualified Intellectual Disabilities Professional on 2/23/16 at 2:50 PM stated client #4 wore oxygen due to "constant Pneumonia." The QIDP stated during client #4's last hospitalization "We thought she would not make it. O2 to keep lungs open. Lungs are in a bad way."</p> <p>Interview with RN (Registered Nurse) #1 and the QIDP on 2/23/16 at 3:12 PM indicated client #4 had an order to wear continuous oxygen. RN #1 stated "[Client #4] needs constant air as O2 saturation drops." RN #1 indicated the client's doctor was hoping the oxygen would help prevent client #4 from getting Pneumonia. RN #1 indicated client #4 lungs were not good. RN#1 indicated client #4's oxygen saturation levels were</p>			

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	<p>not being monitored/documented. RN #1 indicated client #4's Pneumonia Protocol did not include client #4's wearing continuous oxygen.</p> <p>2. During the 2/22/16 observation period between 4:29 PM and 6:30 PM and during the 2/23/16 observation period between 6:05 AM and 8:00 AM, at the group home, client #2 did not wear eyeglasses.</p> <p>Client #2's record was reviewed on 2/23/16 at 10:06 AM. Client #2's 10/21/15 ISP indicated client #2 wore glasses as the client was "nearsighted."</p> <p>Client #2's 5/22/15 Eye Exam report indicated "Good vision-mild change in glasses...New glasses prescribed...."</p> <p>Client #2's 10/21/15 ISP and/or 5/22/15 vision examination did not indicate if client #2 was to wear her eyeglasses all the time and/or just as needed for reading etc.... Client #2's ISP and/or record did not indicate the facility's nurse obtained clarification in regard to when client #2 was to wear her eyeglasses.</p> <p>Interview with RN #1 and the QIDP on 2/23/16 at 3:12 PM indicated client #2 had eyeglasses. The QIDP and RN #1 stated client #2 was to wear her</p>			

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	<p>eyeglasses "as needed. They are just to help her. Low dose." The QIDP indicated client #2 would decide not to wear her eyeglasses. RN #1 and the QIDP indicated they needed to obtain clarification on when client #2 was to wear her eyeglasses as the 5/15 vision examination form did not specify when the client was to wear her eyeglasses.</p> <p>3. During the 2/22/16 observation period between 4:29 PM and 6:30 PM and during the 2/23/16 observation period between 6:05 AM and 8:00 AM, at the group home, client #2 wore a gauze wrap around her right elbow.</p> <p>Interview with client #2 on 2/23/16 at 7:30 AM indicated client #2 had a gauze bandage on her arm. When asked what happened, client #2 stated "I scratched myself." Client #2 indicated she had scratched her arm when she was upset.</p> <p>Client #2's record was reviewed on 2/23/16 at 10:06 AM. Client #2's T-Logs (Therap computer system daily progress notes) indicated the following (not all inclusive):</p> <p>-2/18/16 Client #2 picked her fingers and asked for a bandaid.</p> <p>-2/6/16 Client #2 was picking her fingers. The note indicated facility staff had client</p>			

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W 9999	<p>#2 "put her gloves on." Client #2's 2016 T-Logs did not indicate client #2 picked an area/scab on her elbow, and/or indicate the facility's nurse was notified of the elbow area.</p> <p>Client #2's 6/22/15 Behavior Support Plan (BSP) indicated client #2's diagnosis included, but was not limited to, Smith-Magenis Syndrome which was demonstrated by "Skin picking: Picking or biting finger nails until bleeding" and "Skin Rubbing: Rubbing or scratching skin until it bleeds or scabs."</p> <p>Interview with RN #1 and the QIDP on 2/23/16 at 3:12 PM indicated they were not aware of the area on client #2's elbow. RN #1 indicated she checked client #2's T-Logs and facility staff did not indicate client #2 had picked an area/scab on her elbow. RN #1 indicated she did not know why client #2's elbow was wrapped in gauze. The QIDP indicated she thought facility staff may have wrapped the client's arm upon client #2's request. RN #1 indicated facility staff should have sent her an email in regard to the elbow area.</p> <p>9-3-6(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G726	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/29/2016
NAME OF PROVIDER OR SUPPLIER OPPORTUNITY ENTERPRISES			STREET ADDRESS, CITY, STATE, ZIP CODE 501 ALBERT ST VALPARAISO, IN 46383		
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Bldg. 00	<p>STATE FINDINGS:</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met.</p> <p>(1) 460 IAC 9-3-3 Facility Staffing</p> <p>(e) Prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin (TB) test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. If the skin test result is significant (ten (10) millimeters or more), then a chest film shall be done with other physical and laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the physician.</p> <p>THE STATE RULE WAS NOT MET AS EVIDENCED BY:</p> <p>Based on record review and interview for 1 of 3 personnel records reviewed, the facility failed to obtain a yearly PPD and/or a chest x-ray for an employed</p>	W 9999	To ensure that no other staff were out of compliance, Human Resources completed an audit of all employee files and no other employees at this group home were found to be out of compliance with TB testing. Staff 3 completed a TB test on 2.26.15 and the results were negative. To ensure this deficient practice does not reoccur, Human Resources will audit employee files on a monthly basis.	03/18/2016	

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	<p>staff.</p> <p>Findings include:</p> <p>Staff #3's personnel record was reviewed on 2/23/16 at 11:49 AM. Staff #3's personnel record indicated staff #3 last had a Mantoux/Tuberculosis skin test on 1/12/15. Staff #3's personnel record indicated the staff person did not have a current chest x-ray and/or Mantoux test to ensure the staff person was free of TB.</p> <p>Interview with the Human Resource Director (HRD) on 2/23/16 at 1:26 PM indicated staff #3 did not have a current TB test. The HRD stated "She is out of compliance. Told she has to go today." The HRD indicated staff #3 was given the paperwork in January 2016 to get the TB test done.</p> <p>9-3-3(e)</p>						