

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G640	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2012
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NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3102 AIRPORT RD PORTAGE, IN 46368
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W0000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: June 5, 6, 7 and 8, 2012.</p> <p>Facility number: 001220 Provider number: 15G640 AIM number: 100245730</p> <p>Surveyor: Kathy Wanner, Medical Surveyor III.</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review was completed on 6/14/12 by Tim Shebel, Medical Surveyor III.</p>	W0000		
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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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W0140	<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.</p> <p>Based on record review and interview, the facility failed to establish and maintain a system to assure a complete and full accounting of the personal funds for 5 of 5 clients living in the home (clients #1, #2, #3, #4 and #5).</p> <p>Findings include</p> <p>Facility records were reviewed on 6/6/12 at 12:04 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports for the past year. The BDDS reports indicated the following:</p> <p>A BDDS report dated 1/6/12 at 800 P.M. indicated "As the SGL (Supported Group Living) Manager was balancing consumer bank books, she realized that [client #4] was missing some receipts and change from a shopping trip he took with his sister around Thanksgiving time, and [client #1] was missing approximately \$55.00 in change from a shopping trip also in November. Upon further review, she also concluded that the consumer Christmas Gift Cards given from the Day Program in the amount of \$10.00 each were missing. She contacted her</p>	W0140	Cite 140 – The policy was previously revised to include a monthly audit of all residents' funds by the Financial Controller. Along with this the Lead Manager completes a monthly audit of the residents' funds and a locked box has been placed in all group homes to keep the money secured at all times. The Group home manager received a corrective action for poor job performance in regards to the cited incident. The staff will be retrained on 6/22/12 on the procedure of placing all money in the secured box if the manager is unavailable to take the money. The Vice President of Consumer Services will monitor on a monthly basis to ensure compliance.	07/08/2012			

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	<p>supervisor who asked her to conduct a thorough search of the office to determine if the receipts and change could be located. When they still didn't show up, a report was completed, and notifications were made. An investigation was initiated. It was determined that when [client #4] returned from his shopping trip with his sister, the receipts and change were put in the manger's office to be put in the money lock box. Similarly, the \$55.00 change from [client #1's] shopping was also said to have been put in her (manager's) office under a file folder until it could be put in the lock box. While looking in her office and and her mailbox for the receipts/change, the manager also discovered the gift cards were no longer there. She last remembered seeing them on Dec. (December) 28th.) Due to the length of time elapsed since the November shopping trips until now, it is nearly impossible to determine which staff may be responsible for the missing money, and there fore (sic), who to suspend. Alternately the request was made to bring the lock box and ledgers into the main office until the investigation could be completed so not to further potential of missing funds...the manager will receive corrective action for poor Job Performance...."</p> <p>Internal investigation documentation was</p>						

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	<p>reviewed on 6/6/12 at 2:45 P.M.. The investigation documentation indicated "[Client #1] was reimbursed for \$55.00 on 1/13/12 and a \$10.00 gift card on 1/12/12, [client #2] was reimbursed a \$10.00 gift card on 1/12/12, [client #3] was reimbursed a \$20.00 gift card on 1/12/12, [client #4] was reimbursed for \$50.00 on 1/13/12 and a \$10.00 gift card on 1/12/12, [client #5] was reimbursed a \$10.00 gift card on 1/12/12."</p> <p>An interview with the Qualified Developmental Disabilities Professional Designee (QDDPD) was conducted on 6/7/12 at 2:47 P.M.. The QDDPD stated, "Yes, money was missing, the clients were reimbursed." The QDDPD stated there was a new financial system in place which included "at least monthly audits of the clients money by the SGL, the lead manager, and the financial department staff." 9-3-2(a)</p>			

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W0249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on record review and interview, a facility staff failed to follow a Risk Protocol for 1 of 3 sampled clients (client #1) resulting in a fall with injury requiring medical treatment.</p> <p>Findings include:</p> <p>Facility records were reviewed on 6/6/12 at 12:04 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports for the past year. The BDDS reports indicated the following:</p> <p>A BDDS report dated 10/28/11 at 4:15 P.M. indicated "[Client #1] was sitting on the toilet when staff turned approximately 6in (six inches) and pivoted to move her shoe and brace from the walkway... When staff turned without warning [client #1] fell over off the toilet. Staff immediately got [client #1] up off the floor. [Client #1] was alert and staff assessed [client #1's] face. [Client #1] had a 1" (one inch) gash under her chin that was bleeding. Staff applied pressure and contacted the nurse</p>	W0249	Cite 249 - The QDDP-D will retrain staff on 06/22/12 in regards to utilizing Client #1's seat belt in the bathroom and all other adaptive devices that ensure the safety of the consumers. This will be monitored by the QDDP-D during monthly house visits to ensure compliance.	07/08/2012			

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	<p>who directed [client #1] be taken to the ER (emergency room). While at the ER [client #1] received 3 (three) stitches, discharge orders are to keep Band-Aid on with antibiotic ointment for 2 (two) days. Wash with soap and water on the third day. [Client #1] to follow up with her primary doctor in 5-7 (five to seven) days to remove stitches... [Name QDDPD] (Qualified Developmental Disabilities Professional Designee) spoke with the staff inquiring about the belt that is to be utilized around the toilet. Due to previous falls [client #1] has a seat belt on the toilet to ensure her safety that has been HRC (Human Rights Committee) approved. Staff replied that the seat belt was not utilized due to [client #1] not having pseudo seizures. I (QDDPD) counseled staff on the importance of always using the belt..."</p> <p>Hospital Discharge records dated 10/28/11 were reviewed on 6/6/12 at 12:04 P.M.. The discharge information indicated "There is an uncomplicated horizontal laceration located over the lower aspect of chin which is 3 cm (three centimeters) in length."</p> <p>Client #1's record was reviewed on 6/7/12 at 12:15 P.M.. Client #1's record included a Fall Protocol dated 4/9/12 which indicated client #1 was "high risk for</p>						

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	<p>falling." Client #1 had a High Risk Protocol dated 4/22/11 which indicated "she had a history of falling off the toilet." Staff were to assist her, support bars were placed on either side of the toilet, and a belt that goes around her (client #1's) waist and offers more aid if she falls forward during a pseudo seizure. Staff will continue to be in the restroom to offer assistance but this will ensure she does not fall off and injure herself during a pseudo seizure."</p> <p>An interview with the Qualified Developmental Disabilities Professional Designee (QDDPD) was conducted on 6/7/12 at 2:47 P.M.. The QDDPD stated, "Yes, staff did not follow her risk plan, she was to use the belt on the toilet at all times."</p> <p>9-3-4(a)</p>			

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W0289	<p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart.</p> <p>Based on observation, record review and interview, the facility failed to incorporate the use of a Door Aggress with a delayed release of fifteen seconds into the Behavior Support Plan (BSP) / Individual Support Plan (ISP) for 1 of 3 sampled clients (client #2).</p> <p>Findings include:</p> <p>Observations were conducted at the group home where client #2 lived on 6/5/12 from 5:09 P.M. until 7:28 P.M.. The group home was located on a busy two lane street. The front door to the home was 10-15 yards from the street. The front door of the home was a steel door with a locking mechanism which would allow for egress 15 seconds after the bar of the door was pushed. The door alarm would sound once the bar was pushed allowing staff 15 seconds to get to the door before the door would open. Staff carried keys to the door which would/could be utilized to open the door immediately without the alarm sounding.</p>	W0289	<p>Cite 289 – The QDDP-D added the restrictive measure of the door egress in Client #2's BSP and ISP. The QDDP-D has been retrained on including systematic interventions in the ISP and BSP for anyone who requires these interventions. Future compliance will be monitored by the Vice President of Consumer Services through the annual review of BSP's and ISP's.</p>	07/08/2012	

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	<p>Client #2's record was reviewed on 6/7/12 at 12:50 P.M.. Client #2's record indicated he had an ISP dated 10/5/11. The ISP for client #2 did not include the use of a door with a delayed release. Client #2's record indicated he had a BSP dated 8/2/11. Client #2's BSP indicated he had the following targeted behaviors, "Bolting, PICA, Physical Aggression, Screaming, and Property Mishandling/Destruction." Client #2's BSP included the following proactive and reactive interventions "30 minute rewards, increase communication, explain why earned reward and when/how to earn next reward, staff to monitor closely and check on him at least every ten minutes, give positive attention, and a hierarchy of least restrictive to most restrictive physical interventions." Client #2's BSP did not include the use of a delayed release door.</p> <p>An interview with the Supported Group Living (SGL) Manager was conducted on 6/7/12 at 7:03 A.M.. The SGL indicated client #2 would run out the old door and could make it to the street before staff could reach him. The SGL stated, "He is very tall, has long legs and can run very fast, and the house is really close to the street we were afraid he was going to run out on the street and get hit."</p>						

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	An interview with the Qualified Developmental Disabilities Professional Designee (QDDPD) was conducted on 6/7/12 at 2:47 P.M.. The QDDPD stated, "No, the aggress door is not in his plan." The QDDP indicated the HRC (Human Rights Committee) had approved the use of the delayed release door. 9-3-5(a)			

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W9999	<p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met.</p> <p>460 IAC 9-3-3 Facility Staffing</p> <p>Sec. 3. (a) The residential facility shall meet all conditions specified in 42 CFR 483.430.</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 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>This rule was not met as evidenced by:</p> <p>Based on record review and interview, the</p>	W9999	<p>Cite 9999 – On 6/22/12 employees were retrained on the proper procedure of having their TB test completed in the correct time frame. Employees were reminded that it is their responsibility to ensure that when the TB form is received it must be completed. Staff # 2 has had his TB test completed with results of 0 millimeters of induration. To ensure future compliance TB testing is monitored by the HR Specialist.</p>	07/08/2012

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	<p>facility failed to ensure 1 of 2 staff (staff #2) files reviewed had an annual mantoux test in accordance with state law.</p> <p>Findings include:</p> <p>Facility employee records were reviewed on 6/6/12 at 4:32 P.M. and indicated staff #2 had last received a Mantou test given on 6/28/2010 and read on 6/30/2010 with a result of 0 millimeters of induration.</p> <p>An interview with the Qualified Developmental Disabilities Professional Designee (QDDPD) was conducted on 6/7/12 at 1:35 P.M.. The QDDPD stated, "[Staff #2] did not have an updated TB test."</p> <p>9-3-3(e)</p>			