STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G511	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/04/2015

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

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W 0000 Bldg. 00	This visit was for a recertification and state licensure survey. This visit included the investigation of Complaint #IN00170404. COMPLAINT #IN00170404 - SUBSTANTIATED, Federal/State deficiencies related to the allegation are cited at W104 and W140. Dates of Survey: April 28, 29, 30, May 1 and 4, 2015. Facility number: 001025 Provider number: 15G511 AIM number: 100245170 The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.	W 0000		
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review, observation, and interview for 3 of 3 sampled clients (A,	W 0104	The facility has updated the abuse and neglect policy, see attached, to include that any	05/18/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	B, and C), and 3 additional clients (clients D, E, and F), the facility's Governing Body failed to exercise general operating direction over the facility by failing to include/implement policies and procedures which included/addressed the Elder Justice Act; which requires specific individuals in applicable long term care facilities to report any reasonable suspicion of crimes committed against a resident of that facility; (pursuant to 6703(B)(3) of The Patient Protection and Affordable Care Act of 2010 according to section 1150B of the Social Security Act.) Findings include: The facility's records were reviewed on 4/28/15 at 12:34 P.M. Review of incident reports from 4/28/14 to 4/28/15 indicated the following: - "Name: [Clients A, B, C, D, E, and F], Date: 03/24/2015, Narrative: It was reported that the Group Home Director went to the group home to manage client funds and noticed the ledgers had not been reconciled as scheduled and did not balance. Consequently, the Director then took the ledgers to the financial department for further audit, where it was determined the exact amount of missing		suspicion of crime will be reported to local law enforcement as required by the Elder Justice Act. Further, it includes that any and all notifications will be documented in the conclusive abuse and neglect report.	

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	funds. [Client C] - $500 check {missing receipts to verify purchase}, $5.23 cash; [Client D], - $5.85 cash; [Client A] $100 check {missing receipts to verify purchase}, $171.97 cash; [Client E] - $140 cash; [Client F] - $400 check {missing receipts to verify purchase}, $159.55 cash; [Client B] - $272.99 cash. Total: $1000 in checks, $755.59 in cash. Plan to Resolve: Upon notification of the unaccounted funds/missing receipts, an investigation was initiated. The investigation is ongoing and the agency is looking for receipts to account for the missing money. The manager who is responsible for fund management is currently on FMLA (Family Medical Leave Act), therefore is suspended from client contact/fund management. The manager will remain on suspension through the entirety of the investigation. New internal procedures have been developed and will be put into place for all group homes to prevent further fund mismanagement. As part of the investigation, it was determined that the Financial Department staff responsible for conducting monthly audits of the fund management had not done so since September 2014 and will receive corrective action for the infraction committed. If missing funds cannot be accounted for, (the facility) will reimburse all client funds at the			

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

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	conclusion of the investigation." Director of Residential Services #1 was interviewed on 4/28/15 at 1:11 P.M. Director of Residential Services #1 stated, "Based on our investigation it has been determined that the house manager must have taken the client money." When asked if the theft of client funds had been reported to the local police, Director of Residential Services #1 said, "No." During observations at the facility on 4/28/12 from 4:11 P.M. until 5:30 P.M., and on 4/29/15 from 5:29 A.M. until 7:30 A.M., clients A, B, C, D, E, and F were observed to be living in the facility. Environmental tours of the facility during the observation times failed to indicate posted documentation regarding the Elder Justice Act and the rights/responsibilities thereof. Direct care staff #1 and #2 were interviewed on 4/28/15 at 4:55 P.M. Both direct care staff #1 and #2 stated they had "heard of the Elder Justice Act but did not know anything else about it." Direct care staff #3 and #4 were interviewed on 4/29/15 at 7:33 A.M. Both direct care staff #3 and #4 stated they had "heard of the Elder Justice Act"			

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	but "have not had any training on it." The Chief Program Officer was interviewed on 4/29/15 at 9:27 A.M. regarding the required implementation of the Elder Justice Act. The interview indicated the agency was aware of the Elder Justice Act, but had not implemented policies and procedures, nor had trained direct care staff on the Elder Justice Act at the time of survey. This federal tag relates to complaint #IN00170404. 9-3-1(a)			
W 0140 Bldg. 00	483.420(b)(1)(i) CLIENT FINANCES 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 record review and interview the facility failed to hold an accurate accounting of client funds for 3 of 3 sampled clients (A, B, and C), and 3 additional clients (clients D, E, and F). Findings include:	W 0140	All clients, affected by this deficient practice, have been fully reimbursed by the agency. To ensure this deficient practice will not reoccur; the agency has made systematic changes, outlined in a newly revised client rights-financial management policy (see attached).	05/18/2015

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	The facility's records were reviewed on 4/28/15 at 12:34 P.M. Review of incident reports from 4/28/14 to 4/28/15 indicated the following: - "Name: [Clients A, B, C, D, E, and F], Date: 03/24/2015, Narrative: It was reported that the Group Home Director went to the group home to manage client funds and noticed the ledgers had not been reconciled as scheduled and did not balance. Consequently, the Director then took the ledgers to the financial department for further audit, where it was determined the exact amount of missing funds. [Client C] - $500 check {missing receipts to verify purchase}, $5.23 cash; [Client D], - $5.85 cash; [Client A] $100 check {missing receipts to verify purchase}, $171.97 cash; [Client E] - $140 cash; [Client F] - $400 check {missing receipts to verify purchase}, $159.55 cash; [Client B] - $272.99 cash. Total: $1000 in checks, $755.59 in cash. Plan to Resolve: Upon notification of the unaccounted funds/missing receipts, an investigation was initiated. The investigation is ongoing and the agency is looking for receipts to account for the missing money. The manager who is responsible for fund management is currently on FMLA (Family Medical Leave Act), therefore is suspended from			

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	client contact/fund management. The manager will remain on suspension through the entirety of the investigation. New internal procedures have been developed and will be put into place for all group homes to prevent further fund mismanagement. As part of the investigation, it was determined that the Financial Department staff responsible for conducting monthly audits of the fund management had not done so since September 2014 and will receive corrective action for the infraction committed. If missing funds cannot be accounted for, (the facility) will reimburse all client funds at the conclusion of the investigation." Director of Residential Services #1 was interviewed on 4/28/15 at 1:11 P.M. Director of Residential Services #1 stated, "The money (client funds) had not been reconciled and the financial department had not been auditing consumer (client) funds since last fall (fall of 2014)." This federal tag relates to complaint #IN00170404. 9-3-2(a)			

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W 0369 Bldg. 00	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review, and interview, the facility failed to assure 1 of 8 administered medications were administered according to physician's orders for 1 of 3 additional clients (clients F). Findings include: Client F was observed during the group home observation period on 4/29/15 from 5:29 A.M. until 7:30 A.M. At 6:50 A.M., client F ate his breakfast which consisted of cereal, toast, and milk. At 7:09 A.M., direct care staff #3 administered a 40 mg (milligram) tablet of Omeprazole (medication to reduce stomach acid). Client F's record was reviewed on 5/1/15 at 9:22 A.M. Review of client F's 2/13/15 physician's orders indicated the following order: "Omeprazole Cap (Capsule) 40 mg Take 1 capsule by mouth daily 30 to 60 minutes before meal."	W 0369	The facility has ensured that no other clients were affected by the deficient practice. On April 29th, the group home nurse amended the medication administration record to guarantee that the client's omeprazole will be given at 5:30am, instead of the prescribed previous of 6:00am through 9:00am. On April 29th, the group home nurse retrained direct care staff #3 on the proper administration of client F's omeprazole. To ensure the deficient practice does not reoccur, the QDDP will conduct random monthly home visits and the facility's nurse will conduct random monthly visits. During these random observations, competency will need to be demonstrated and observations will be documented. If it is determined, at any time, that staff fail to follow the policy for medication administration, they will be required to retake Med Core A and B,within 30 days, as taught by a certified nursing instructor. The staff will be suspended from passing medications, during this time. To ensure training was effective, the facilities group home nurse	05/04/2015

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	Nurse #1 was interviewed on 5/1/15 at 9:39 A.M. Nurse #1 stated, "Direct care staff should have administered [client F's] Omeprazole according to the physician's order." 9-3-6(a)		conducts random site visits, as well as medication administration record reviews to safeguard against medication errors. If, at any time, it is determined that staff'straining was not effective; they will be suspended from passing medications and re-trained by a facility nurse, which will include going through six supervised medication passes.	
W 0440 Bldg. 00	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed to conduct evacuation drills during the overnight shift (11:00 P.M. to 7:00 A.M.) for staff during the first quarter of 2015 (January 1st through March 31st) which affected 3 of 3 sampled clients (clients A, B, and C) and 3 additional clients living in the facility (clients D, E, and F). Findings include: The facility's records were reviewed on 5/1/15 at 9:41 A.M. The review failed to indicate the facility held an evacuation drill for staff during the overnight shift during the first quarter of 2015. This affected clients A, B, C, D, E, and F who lived in the facility.	W 0440	Evacuation drills will be conducted a minimum of once per quarter for each shift. The GHM will schedule these drills and see that they are completed. Once a drill is conducted, the drill form will be signed by the staff on shift and will include information on the client's in the home as far as their level of participation/assistance required in the dill. Once these forms are completed, they will be turned into the Executive Assistant to Programs. As part of a systematic change, she/he will add this drill tracking to a checklist of monthly action items and will ensure that all drills are conducted within the regulatory time frames.	05/04/2015

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	Director of Residential Services #1 was interviewed on 5/1/15 at 10:17 A.M. Director of Residential Services #1 stated, "They (direct care staff) must have forgotten to do one (evacuation drill) for the overnight shift." 9-3-7(a)			