STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G640	A. BUILDING 00 B. WING	05/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITY ENTERPRISES INC	3102 AIRPORT RD PORTAGE, IN 46368

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W 0000 Bldg. 00	This visit was for a predetermined full recertification and state licensure survey. This visit included the COVID-19 focused infection control survey. Survey Dates: May 24, 25, and 26, 2021. Facility Number: 001220 Provider Number: 15G640 AIMS Number: 100245730 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 6/9/21.	W 0000		
W 0154 Bldg. 00	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 1 of 5 allegations of abuse, neglect, exploitation, and mistreatment reviewed, the facility failed to conduct a thorough investigation regarding 1 allegation of neglect for client #3. Findings include: The facility's Bureau of Developmental Disabilities Services (BDDS) reports and related investigations were reviewed on 5/24/21 at 11:19 am. A BDDS report dated 5/14/21 indicated the following: "While staff was assisting other clients, [client #3] got up from the living room to go into the	W 0154	The practice of not consistently and thoroughly investigating an allegation of abuse/neglect for client #3 (PICA behavior) has the potential to affect all individuals in the home. On 5/26/21, the Residential Services Senior Director (RSSD) trained the QIDP's on the importance of state policy regarding thorough investigations and reviewed with them OE's Abuse and Neglect policy. The Group Home Director, or designee, will audit General Event Reports every 5-business days for 3 months to ensure that all policy timelines are	05/26/2021

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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	back client bathroom. He was in there for at most 15 - 30 seconds unattended. In that timeframe, [client #3] found disinfectant spray under the bathroom sink and ingested an unknown amount. Staff was not aware this was there, as all cleaning supplies are to be placed in a locked cabinet." - The review did not include an investigation was completed. Director #1 was interviewed on 5/25/21 at 1:00 pm and stated, "Allegations of neglect are investigated and are completed within 5 business days." 9-3-2(a)		being met by the QIDP's. If after 3 months, all policy requirements are being met, the reviews will back down to a random basis. Further, OE's Incident Review Team meets monthly and will provide ongoing review of each incident to ensure the investigative forms are attached to any incident having required an internal investigation.	
W 0312 Bldg. 00	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 record review and interview for 2 of 3 sampled clients (#1 and #2), the facility failed to develop a behavior plan and a medication reduction plan for clients #1 and #2's psychotropic medications. Findings include: 1. Client #1's record was reviewed on 5/24/21 at 12:07 pm. Client #1's MAR (Medication Administration Record) dated May 2021 indicated the following psychotropic medications: "Invega (used to treat schizophrenia) TAB (tablet)	W 0312	Failure to meet this standard could potentially affect all residents who take a psychotropic medication. On 6/11/21, the Residential Services Senior Director (RSSD) trained the QIDP's and agency nurse on the importance of having a medication reduction plan for all psychotropic medications. The QIDP's will update individual #1 and #2's ISP to reflect their medication reduction plans. The RSSD or designee will review all ISP's on a quarterly basis to ensure reduction plans are put in	06/17/2021

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	6 mg (milligrams). Take 1 tablet by mouth daily." "Strattera (used to treat attention deficit hyperactivity disorder) CAP (capsule) 40 mg. Take 1 capsule by mouth daily." "Trazodone (used to treat depression and anxiety) TAB 50 mg. Take 1 tablet by mouth at bedtime." - Client #1's record did not indicate a plan regarding the use of psychotropic medications. 2. Client #2's record was reviewed on 5/24/21 at 12:17 pm. Client #2's MAR dated May 2021 indicated the following psychotropic medications: "Divalproex TAB 250 mg Take 1 tablet by mouth every evening for seizures." "Divalproex TAB 500 mg. Take 1 tablet by mouth twice daily seizures." "Quetiapine (used to treat schizophrenia, bipolar disorder, and depression) TAB 25 mg Take 1 tablet by mouth every evening." - Client #2's record did not indicate a plan regarding the use of psychotropic medications. Registered Nurse (RN) #1 was interviewed by phone on 5/25/21 at 12:55 pm and stated, "[Client #1] has bipolar disorder. The medications treat part of the highs that come with it. It puts him on more of an even plane." RN #1 stated, "[Client #2] doesn't have a diagnosis, but we've seen some neurological changes, and the neurologist prescribed the medications."		place. These quarterly reviews will take place for 9 months and if the same QIDP's remain in position, and reduction plans are properly accounted for, the reviews will go to a random basis. If a QIDP leaves and a new one is hired, the 9-month clock will start over to ensure the new QIDP is following the standard. All ISP's will updated by the QIDP on an annual basis. If a client is prescribed a new psychotropic, the new order will be discussed in the monthly IDT and the QIDP will be responsible to add it to the existing ISP.	

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	Director #1 was interviewed on 5/25/21 at 1:00 pm and indicated client #1 and #2's plans do not address the use of psychotropic medications. 9-3-5(a)			
W 0455 Bldg. 00	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation, record review, and interview for 1 additional client (#4), the facility failed to ensure staff working in the home implemented universal precautions for hand hygiene. Findings include: Observations were conducted at the group home on 5/24/21 from 4:08 pm through 6:30 pm and on 5/25/21 from 6:00 am through 7:00 am. Client #4 was present in the group home throughout the observation period. On 5/24/21 at 4:30 pm, Direct Support Professionals #3 and #5 changed client #4's clothing and brief. DSPs #3 and #5 did not wash or sanitize client #4's hands after changing him. At 5:00 pm, DSP #1 brought client #4 to the medication room in his wheelchair. DSP #1 did not wash or sanitize client #4's hands before passing his medications. At 5:23 pm, client #4 was served his evening meal. Staff did not wash or sanitize client #4's hands before feeding him.	W 0455	The failure to implement hand hygiene precautions could affect all residents. On 6/3/21, the Residential Services Senior Director (RSSD) trained all staff in the home on the importance of good hand hygiene. Proper hand washing has been added to the QIDP monthly checklist to ensure its happening during their visits. The completed checklists are sent to the RSSD, Group Home Director (GHD) and Group Home Manager (GHM) for review. The RSSD will monitor for completion on an ongoing basis. Additionally, the GHD will make random house visits and be cognizant of watching for hand hygiene. She will notify the RSSD and GHM of any concerns or deficiencies noted.	06/03/2021

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	DSP #1 was interviewed on 5/24/21 at 5:11 pm and stated, "I did wash my hands, but I did not wash [client #4's] hands. I assumed he already had because they changed him." Registered Nurse (RN) #1 was interviewed by phone on 5/25/21 at 12:55 pm and stated, "Clients' hands should be washed after toileting, before medication pass, and before eating." The Living in the Community: Medication Administration Manual (2004) (curriculum used to train group home staff for medication administration), reviewed on 5/25/21 at 2:00 pm, indicated the following: "All staff should wash their hands utilizing aseptic technique upon arrival to work or after handling infectious materials without the use of personal protective equipment (gloves). In the absence of a true emergency, personnel should wash their hands with soap and water or a hand sanitizer for at least 30 seconds, utilizing friction from the wrists down. Hands should be washed: before and between caring for each individual...." 9-3-7(a)			
W 9999 Bldg. 00	State Findings: The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met. 460 IAC 9-3-3 Facility Staffing	W 9999	9999 – Final Observations (failure to ensure a Mantoux screening) Failure to ensure completion of Mantoux (TB) Screening could affect all residents. For those staff who did not have a completed Mantoux test on file at the time of the ISDH survey, the	06/03/2021

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	(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. This state rule was not met as evidenced by: Based on record review and interview for 2 of 3 employee files reviewed, the facility failed to ensure a Mantoux (5TU, PPD) tuberculosis (TB) screening was conducted before employment and annually thereafter. Findings include: The facility's employee files were reviewed on 5/25/21 at 12:03 pm and indicated the following: 1. Direct Support Professional (DSP) #1's record indicated a start date of 12/6/19. DSP #1's record did not include evidence of a tuberculosis screening. 2. DSP #2's record indicated a start date of 8/7/17. DSP #2's record did not include evidence of a tuberculosis screening. Registered Nurse (RN) #1 was interviewed by phone on 5/25/21 at 12:55 pm and stated, "Staff get their tuberculosis screenings done annually.		Agency nurse attended the homes' 6-3-21 Staff meeting in which she administered all tests. HR will monitor each staff's TB screening status through our HRIS system during a monthly audit process. If it is discovered that a staff is due for an upcoming TB screening, HR will notify the staff and their respective Manager of the need to complete the screening. Staff will be given 30-day notice prior to their expiration. The HR Liaison will ensure each staff's screening is completed up on the next monthly audit.	

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	They should have one completed before they are hired." 9-3-3(e)			