STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G735		09/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM OCCAZIO LLC	1206 S MAIN ST NEW CASTLE, IN 47362

(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
W 0000 Bldg. 00	This visit was for the investigation of complaint #IN00200306. Complaint #IN00200306: Substantiated, federal/state deficiencies related to the allegation are cited at W102, W104, W122, W149, W153, and W154. Unrelated deficiency cited. Dates of Survey: 9/14, 9/15, 9/16, 9/19, and 9/20/2016. Provider Number: 15G735 Facility Number: 005553 AIM Number: 200854080 These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 10/3/16.	W 0000		
W 0102 Bldg. 00	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on interview and record review, the facility failed to meet the Condition of Participation: Governing Body for 2	W 0102	**W102 Governing Body and Management (CONDITION)** The facility must ensure that the specific governing body and	10/20/2016

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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NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362	

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	of 3 sampled clients (clients A and B) and 2 additional clients (clients F and G). The governing body failed to ensure the facility staff implemented the agency's policies and procedures for abuse, neglect, and/or mistreatment to ensure allegations were immediately and accurately reported and thoroughly investigated for clients A, B, F and G. Findings include: Please refer to W104. The governing body failed for 2 of 3 sampled clients (clients A and B) and 2 additional clients (clients F and G) to exercise general policy, budget, and operating direction over the facility to ensure the facility staff implemented the agency's abuse, neglect, and/or mistreatment policy and procedure to immediately and accurately report and to thoroughly investigate allegations of abuse, neglect, and/or mistreatment for clients A and B's illegal drug lab (laboratory) results and clients F and G's allegation of staff abuse. Please refer to W122. The governing body failed to ensure facility met the Condition of Participation: Client Protections for 2 of 3 sampled clients (clients A and B) and 2 additional clients (clients F and G). The governing body failed to ensure the agency's abuse, neglect, and mistreatment		management requirements are met. **1. What corrective action will be accomplished?** •□□□□□□□□ Staff, Program Coordinator and Program Director (QIDP) will be retrained on reporting and documenting all incidents of possible illegal drug use. •□□□□□□□□ Program Director will be retrained on investigation protocol and timeliness for incidents of possible illegal drug use. •□□□□□□□□ Monthly, the facility nurse, Program Coordinator and Program Director (QIDP) will meet to review client needs, all client care, incidents and risk plans to ensure client safety. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** •□□□□□□□□ All residents have the potential to be affected by the same deficient practice. •□□□□□□□□ Staff, Program Coordinator and Program Director (QIDP) will be retrained on reporting and documenting all incidents of possible illegal drug use. •□□□□□□□□ Program Director will be retrained on investigation protocol and timeliness for	

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	policy and procedure was implemented to ensure allegations of abuse, neglect, and/or mistreatment were immediately and accurately reported and thoroughly investigated for clients A and B's positive lab results for illegal drugs and clients F and G's allegation of staff abuse. This federal tag relates to complaint #IN00200306. 9-3-1(a)		incidents of possible illegal drug use. •□□□□□□□□ Monthly, the facility nurse, Program Coordinator and Program Director (QIDP) will meet to review client needs, all client care, incidents and risk plans to ensure client safety. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** •□□□□□□□ Staff, Program Coordinator and Program Director (QIDP) will be retrained on reporting and documenting all incidents of possible illegal drug use. •□□□□□□□ Program Director will be retrained on investigation protocol and timeliness for incidents of possible illegal drug use. •□□□□□□□ Monthly, the facility nurse, Program Coordinator and Program Director (QIDP) will meet to review client needs, all client care, incidents and risk plans to ensure client safety. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** •□□□□□□□ Staff, Program Coordinator and Program Director (QIDP) will be retrained on reporting and documenting all incidents of possible illegal drug	

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			use. •□□□□□□□ Program Director will be retrained on investigation protocol and timeliness for incidents of possible illegal drug use. •□□□□□□□ Monthly, the facility nurse, Program Coordinator and Program Director (QIDP) will meet to review client needs, all client care, incidents and risk plans to ensure client safety. **5. What is the date by which the systemic changes will be completed?** **10/20/16**	
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 interview and record review for 2 of 3 sampled clients (clients A and B) and 2 additional clients (clients F and G), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility staff implemented the agency's abuse, neglect, and/or mistreatment policy and procedure to immediately and accurately report and to thoroughly	W 0104	**W104 Governing Body and Management** The governing body must exercise general policy, budget and operating direction over the facility. The facility must ensure that the specific governing body and management requirements are met. **1. What corrective action**	10/20/2016

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	investigate allegations of abuse, neglect, and/or mistreatment for clients A and B illegal drug laboratory (lab) results and clients F and G's allegation of staff abuse. Findings include: Please refer to W149. The governing body failed for 2 of 2 allegations of abuse, neglect, and/or mistreatment reviewed for 2 of 3 sample clients (clients A and B) and for 2 additional clients (clients F and G) to complete the following: -To ensure the facility implemented the agency's abuse, neglect, and mistreatment policy to protect clients A, B, F, and G from the potential of abuse, neglect and/or mistreatment. -To ensure the facility immediately and accurately reported allegations of clients A and B's positive lab results for the use of illegal drugs to the administrator, and state officials (Bureau of Developmental Disabilities Services-BDDS 9-3-1(b)(5), and/or Adult Protective Services -APS) IC 12-10-3 in accordance with state law. -To ensure thorough investigations of allegations of abuse, neglect, and/or mistreatment and allegations regarding clients A and B's positive lab results of illegal drugs and clients F and G's		**will be accomplished?** •□□□□□□□□ Staff, Program Coordinator and Program Director (QIDP) will be retrained on reporting and documenting all incidents of possible illegal drug use. •□□□□□□□□ Program Director will be retrained on investigation protocol and timeliness for incidents of possible illegal drug use. •□□□□□□□□ Monthly, the facility nurse, Program Coordinator and Program Director (QIDP) will meet to review client needs, all client care, incidents and risk plans to ensure client safety. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** •□□□□□□□□ All residents have the potential to be affected by the same deficient practice. •□□□□□□□□ Staff, Program Coordinator and Program Director (QIDP) will be retrained on reporting and documenting all incidents of possible illegal drug use. •□□□□□□□□ Program Director will be retrained on investigation protocol and timeliness for incidents of possible illegal drug use. •□□□□□□□□ Monthly, the facility	

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	allegation of unsubstantiated staff abuse. Please refer to W153. The governing body failed for 1 of 20 BDDS (Bureau of Developmental Disabilities Services) reports reviewed (client B) and 1 additional report (client A) to ensure the facility immediately and accurately reported allegations of clients A and B's positive lab results for the use of illegal drugs to the administrator, and state officials (Bureau of Developmental Disabilities Services-BDDS 9-3-1(b)(5), and/or Adult Protective Services -APS) IC 12-10-3 in accordance with state law. Please refer to W154. The governing body failed for 2 of 2 allegations of abuse, neglect, and/or mistreatment reviewed for 2 of 3 sample clients (clients A and B) and for 2 additional clients (clients F and G) to ensure thorough investigations of allegations of abuse, neglect, and/or mistreatment and allegations regarding clients A and B's positive lab results of illegal drugs and clients F and G's allegation of unsubstantiated staff abuse were completed. This federal tag relates to complaint #IN00200306. 9-3-1(a)		nurse, Program Coordinator and Program Director (QIDP) will meet to review client needs, all client care, incidents and risk plans to ensure client safety. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** •□□□□□□□ Staff, Program Coordinator and Program Director (QIDP) will be retrained on reporting and documenting all incidents of possible illegal drug use. •□□□□□□□ Program Director will be retrained on investigation protocol and timeliness for incidents of possible illegal drug use. •□□□□□□□ Monthly, the facility nurse, Program Coordinator and Program Director (QIDP) will meet to review client needs, all client care, incidents and risk plans to ensure client safety. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** •□□□□□□□ Staff, Program Coordinator and Program Director (QIDP) will be retrained on reporting and documenting all incidents of possible illegal drug use. •□□□□□□□ Program Director will be retrained on investigation	

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			protocol and timeliness for incidents of possible illegal drug use. •□□□□□□□ Monthly, the facility nurse, Program Coordinator and Program Director (QIDP) will meet to review client needs, all client care, incidents and risk plans to ensure client safety. **5. What is the date by which the systemic changes will be completed?** **10/20/16**	
W 0122 Bldg. 00	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview, the facility failed to meet the Condition of Participation: Client Protections for 2 of 3 sampled clients (clients A and B) and 2 additional clients (clients F and G). The facility failed to ensure the agency's abuse, neglect, and mistreatment policy and procedure was implemented to ensure allegations of abuse, neglect, and/or mistreatment were immediately and accurately reported and thoroughly investigated for clients A and B's positive laboratory (lab) results for illegal drugs and clients F and G's allegation of staff abuse. Findings include:	W 0122	**W 122 Client Protections (CONDITION)** The facility must ensure that certain client protections requirements are met. The facility must ensure that the specific governing body and management requirements are met. **1. What corrective action will be accomplished?** •□□□□□□□□ Staff, Program Coordinator and Program Director (QIDP) will be retrained on reporting and documenting all incidents of possible illegal drug use. •□□□□□□□□ Program Director will be retrained on investigation protocol and timeliness for incidents of possible illegal drug	10/20/2016

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	Please refer to W149. The facility neglected for 2 of 2 allegations of abuse, neglect, and/or mistreatment reviewed for 2 of 3 sample clients (clients A and B) and for 2 additional clients (clients F and G) to complete the following: -To implement the agency's abuse, neglect, and mistreatment policy to protect clients A, B, F, and G from the potential of abuse, neglect and/or mistreatment. -To immediately and accurately report allegations of clients A and B's positive lab results for the use of illegal drugs to the administrator, and state officials (Bureau of Developmental Disabilities Services-BDDS 9-3-1(b)(5), and/or Adult Protective Services -APS) IC 12-10-3 in accordance with state law. -To thoroughly investigate allegations of abuse, neglect, and/or mistreatment and allegations regarding clients A and B's positive lab results of illegal drugs and clients F and G's allegation of unsubstantiated staff abuse. Please refer to W153. The facility failed for 1 of 20 BDDS (Bureau of Developmental Disabilities Services) reports reviewed (client B) and 1 additional report (client A) to immediately and accurately report		use. •□□□□□□□□ Monthly, the facility nurse, Program Coordinator and Program Director (QIDP) will meet to review client needs, all client care, incidents and risk plans to ensure client safety. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** •□□□□□□□□ All residents have the potential to be affected by the same deficient practice. •□□□□□□□□ Staff, Program Coordinator and Program Director (QIDP) will be retrained on reporting and documenting all incidents of possible illegal drug use. •□□□□□□□□ Program Director will be retrained on investigation protocol and timeliness for incidents of possible illegal drug use. •□□□□□□□□ Monthly, the facility nurse, Program Coordinator and Program Director (QIDP) will meet to review client needs, all client care, incidents and risk plans to ensure client safety. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** •□□□□□□□ Staff, Program	

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	allegations of clients A and B's positive lab results for the use of illegal drugs to the administrator, and state officials (Bureau of Developmental Disabilities Services-BDDS 9-3-1(b)(5), and/or Adult Protective Services -APS) IC 12-10-3 in accordance with state law. Please refer to W154. The facility failed for 2 of 2 allegations of abuse, neglect, and/or mistreatment reviewed for 2 of 3 sample clients (clients A and B) and for 2 additional clients (clients F and G) to thoroughly investigate allegations of abuse, neglect, and/or mistreatment and allegations regarding clients A and B's positive lab results of illegal drugs and clients F and G's allegation of unsubstantiated staff abuse. This federal tag relates to complaint #IN00200306. 9-3-2(a)		Coordinator and Program Director (QIDP) will be retrained on reporting and documenting all incidents of possible illegal drug use. •□□□□□□□ Program Director will be retrained on investigation protocol and timeliness for incidents of possible illegal drug use. •□□□□□□□ Monthly, the facility nurse, Program Coordinator and Program Director (QIDP) will meet to review client needs, all client care, incidents and risk plans to ensure client safety. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** •□□□□□□□ Staff, Program Coordinator and Program Director (QIDP) will be retrained on reporting and documenting all incidents of possible illegal drug use. •□□□□□□□ Program Director will be retrained on investigation protocol and timeliness for incidents of possible illegal drug use. •□□□□□□□ Monthly, the facility nurse, Program Coordinator and Program Director (QIDP) will meet to review client needs, all client care, incidents and risk plans to ensure client safety. **5. What is the date by which**	

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			the systemic changes will be completed? **10/20/16**	
W 0149 Bldg. 00	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 2 allegations of abuse, neglect, and/or mistreatment reviewed for 2 of 3 sample clients (clients A and B) and for 2 additional clients (clients F and G): -The facility neglected to implement the agency's abuse, neglect, and mistreatment policy to protect clients A, B, F, and G from the potential of abuse, neglect and/or mistreatment. -The facility neglected to immediately and accurately report allegations of clients A and B's positive lab results for the use of illegal drugs to the administrator, and state officials (Bureau of Developmental Disabilities Services-BDDS 9-3-1(b)(5), and/or Adult Protective Services -APS) IC 12-10-3 in accordance with state law. -The facility neglected to thoroughly investigate allegations of abuse, neglect, and/or mistreatment and allegations	W 0149	**W149 Staff Treatment of Clients** The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. The facility must ensure that the specific governing body and management requirements are met. **1. What corrective action will be accomplished?** •□□□□□□□□ Staff, Program Coordinator and Program Director (QIDP) will be retrained on reporting and documenting all incidents of possible illegal drug use. •□□□□□□□□ Program Director will be retrained on investigation protocol and timeliness for incidents of possible illegal drug use. •□□□□□□□□ Monthly, the facility nurse, Program Coordinator and Program Director (QIDP) will meet to review client needs, all	10/20/2016

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	regarding clients A and B's positive lab results of illegal drugs and clients F and G's allegation of unsubstantiated staff abuse. Findings include: 1. On 9/14/16 at 2:30pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed for the period from 4/1/16 through 9/14/16 and indicated the following for client A: -A 4/22/16 BDDS report for an incident on 4/21/16 at 7:45pm indicated client A was seen in the emergency room (ER) for a seizure. The report indicated client A's "blood work" was "within normal limits." The report did not indicate she had a positive laboratory (lab) result for "THC (Tetrahydrocannabinol also known as the active chemical in marijuana). The positive THC result was not reported to BDDS, the administrator, and APS, and no investigation was available for review. Client A's record was reviewed on 9/15/16 at 10:30am and on 9/16/16 at 9:30am. Client A's 4/21/16 at 7:52am, "Family and Internal Medicine" physician's visit did not include the diagnosis of seizure disorder. Client A's 5/17/16 "Nursing Progress Note"		client care, incidents and risk plans to ensure client safety. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** •□□□□□□□□ All residents have the potential to be affected by the same deficient practice. •□□□□□□□□ Staff, Program Coordinator and Program Director (QIDP) will be retrained on reporting and documenting all incidents of possible illegal drug use. •□□□□□□□□ Program Director will be retrained on investigation protocol and timeliness for incidents of possible illegal drug use. •□□□□□□□□ Monthly, the facility nurse, Program Coordinator and Program Director (QIDP) will meet to review client needs, all client care, incidents and risk plans to ensure client safety. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** •□□□□□□□ Staff, Program Coordinator and Program Director (QIDP) will be retrained on reporting and documenting all incidents of possible illegal drug use.	

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	indicated on "4/21/16 [client A] was seen at [name of hospital ER] (sic) following seizure, drug screen was completed in ER showing P (Positive) THC our staff was not made aware of findings @ (at) d/c (discharge from the ER). Reported findings to MD (client A's personal physician) today when writer was made aware." -Client A's 4/21/16 Hospital ER record regarding her visit to the ER indicated she was seen for a seizure. Client A's 4/22/16 Lab results indicated a urine test and "THC Positive." -Client A's 4/26/16 "T-Log (a staff electronic entry into a client's computerized record)" indicated client A was seen for a seizure at the ER and a follow up appointment was scheduled for 5/11/16. Client A's 4/26/16 "T-Log" indicated her medication "Divalproex (for intermittent explosive disorder) 375mg (milligrams) at 5:00pm remained the same" and her Divalproex 250mg was increased from 250mg to 500mg at 8:00am. -Client A's 4/26/16 "T-Log" indicated she received the Divalproex for intermittent explosive disorder and "not for seizures. [Client A] did not have a diagnosis of Seizure Disorder" and an appointment		•□□□□□□□ Program Director will be retrained on investigation protocol and timeliness for incidents of possible illegal drug use. •□□□□□□□ Monthly, the facility nurse, Program Coordinator and Program Director (QIDP) will meet to review client needs, all client care, incidents and risk plans to ensure client safety. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** •□□□□□□□ Staff, Program Coordinator and Program Director (QIDP) will be retrained on reporting and documenting all incidents of possible illegal drug use. •□□□□□□□ Program Director will be retrained on investigation protocol and timeliness for incidents of possible illegal drug use. •□□□□□□□ Monthly, the facility nurse, Program Coordinator and Program Director (QIDP) will meet to review client needs, all client care, incidents and risk plans to ensure client safety. **5. What is the date by which the systemic changes will be completed?** **10/20/16**	

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	15G735		09/20/2016

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	was made with a neurologist. -Client A's 5/17/16 "T-Log" indicated "IDT (Interdisciplinary Team): Positive THC drug screen. Description: Discussion [client A] went to a (sic) appointment on 4/21 and was told that when [client A] went to the ER visit at [name of hospital] ER doctor implemented a drug screen that came back positive for THC drug." The T-Log indicated the agency nurse was reviewing client A's medications which could have caused "a false-positive" drug screen result for THC. On 9/16/16 at 3:00pm, an interview with the agency RN (Registered Nurse) was conducted. The RN indicated client A was seen in the ER for a seizure on 4/21/16 and a drug screen was completed. The RN indicated the staff who took client A to the ER and the hospital indicated client A's labs were within normal limits. The RN indicated she received a call after the client was seen by the doctor on 5/11/16 for a follow up appointment after the 4/21/16 ER visit and the doctor told the staff and client A about the positive drug results. The RN indicated she was not aware of the positive THC result before 5/17/16 when she was notified by the staff. The RN indicated she reviewed lab results			

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	when the hospital sent the results and the hospital had sent the results of the 4/21/16 ER visit to the doctor and not to the facility. The RN stated client A received routine medications for her Osteoarthrosis, "anti inflammatory medications," and "Gout (a disorder of the muscles characterized by severe pain)" which "could have caused a false positive lab result." The RN stated the medications that "could possibly cause a false positive" were "Allopurinol (for Gout and muscle pain), Colcrys (for Gout and muscle pain), Nabumetone (used to reduce pain and joint stiffness), and Prednisone (used to decrease inflammation)." The RN indicated she did not know if client A's positive THC lab result was reported to BDDS, the Administrator, and APS. The RN indicated client A's physician did not repeat the drug screen to determine if the lab results were accurate or a "false positive" for THC. The RN indicated client A would not identify illegal drugs and was not known to have a history of positive lab results for illegal drugs. The RN indicated client A was admitted on 4/20/15 and had routine labs completed by her doctor. On 9/15/16 at 11:00am, an interview was conducted with the Area Director (AD) and the PC/QIDP (Program			

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	Coordinator/Qualified Intellectual Disabilities Professional). Both professional staff indicated the facility followed the BDDS reporting policy and procedure. Both professional staff indicated the agency was notified on 5/11/16 during a medical follow up appointment with client A's physician that the drug screen completed on 4/21/16 was positive for THC and the agency nurse was notified on 5/17/16 by the facility staff. Both professional staff indicated client A's positive illegal drug result was not reported to BDDS and the AD stated "there was no formal investigation" completed. The AD stated the agency held an IDT on 5/17/16 with the agency nurse and she concluded that client A was receiving routine medications which could have caused a "false positive result." The AD indicated no witness statements, no review outside of the nurse of client A's medical records, no check of the environment, and no repeat drug screen were completed. The AD stated "We had an IDT." When asked if the agency reported the allegation and of drug use, the AD indicated client A's positive lab results should have been investigated and immediately reported. 2. On 9/14/16 at 2:30pm, the facility's BDDS (Bureau of Developmental			

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	Disabilities Services) reports were reviewed for the period from 4/1/16 through 9/14/16 and indicated the following for client B: -A 4/28/16 BDDS report for an incident on 4/27/16 at 2:00pm indicated client B's workshop staff "reported that [client B] was engaging in SIB (Self Injurious Behavior) as evidenced by banging (his) head on the wall. [Client B] then had a seizure. Client currently has a seizure diagnosis. Seizures are currently uncontrolled. Client has a VNS (Vagus Nerve Stimulator) magnet (used to interrupt seizure activity). Group Home staff picked client up and transported [client B] to [name of hospital] ER for evaluation. During ER examination, doctor completed a routine drug screen. Preliminary unconfirmed results suggested client was positive for PCP (Phencyclidine also known as angel dust, an addictive illegal drug that causes hallucinations and produces feelings of detachment). [Name of Behavior Health Service] completed evaluation, stating [client B] was not a threat to himself or others. Client was returned to group home. IDT called emergency meeting 4/28/16. Full investigation will be completed by QI (Quality Internal). Immediate protective measures were put in place including locking chemicals.			

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	One on one staffing during waking hours, line of sight supervision during Narcotics Anonymous (NA) meetings, advocating for inpatient rehabilitation, therapeutic leaves are temporarily on hold, exploring alternatives for NA meetings (NA) meetings are possible source for drugs, considering formal programming to help client identify risks of drug use...." The report did not include an investigation. -A 4/28/16 "Follow Up" BDDS report indicated client B was "in good health at this time. The investigation has proven that [client B] tested a false positive for PCP because he currently takes Lamictal 300mg medication which is one of the 18 drugs that will make a person test a false positive for PCP. An IDT meeting was held today and [client B's] safety and health was the topics (sic). [Client B] will be in the line of sight supervision when in the community being referred to a psychiatrist for mental health assessment...." The report did not include an investigation. -An 4/27/16 "Risk Management Peer Review" indicated client B had SIB at the day program, banged his head on the wall, had a seizure, and was transported to the local hospital ER for evaluation. The review did not include a documented investigation regarding client B's positive			

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	PCP drug screen results, physician notification, interviews with clients and staff, client B's documents reviewed, client B's known history of drug addiction, client B's activities outside the group home, client B's LOA's (Leaves of Absence), client B's current medications, and community supports reviewed. No investigation was available for review. Client B's record was reviewed on 9/15/16 at 11:15am and on 9/16/16 at 1:45pm. Client B's 1/21/16 ISP (Individual Support Plan) and 4/28/16 BSP (Behavior Support Plan) both indicated client B "has been arrested for battery as juvenile, public intoxication and resisting law enforcement as an adult. [Client B] has a long history of alcohol abuse normally 1/2 gallon of liquor or 1/2 case of beer per incident. [Client B] also has a substance abuse issue with marijuana and he smokes regularly...[Client B] states he used Crystal Meth and Crack Cocaine several years ago but no longer has issues with those substances." -Client B's 4/28/16 "T-Log" indicated "IDT met at 9am (sic)...Behaviors he exhibited at [name of workshop]...was engaging in verbal aggression and SIB (Self Injurious Behavior) head butting the wall. [Client B] was upset because his			

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	mother lied to him about what he could and could not do living with [the group home name]. After [client B] head butted the wall he had a tonic clonic seizure and was not injured. [Name of Agency Registered Nurse] requested [client B] go to ER. ER checked [client B's] health status and also done (sic) a urine and blood test for drugs. [Client B] had a false positive reading for PCP because he takes Lamictal medication...." -Client B's 5/16/16 "T-Log" indicated client B's physician was notified on 5/15/16 by the RN to request a statement from client B's physician to indicate client B "had a drug screen that showed a positive PCP result. Lab at [name of hospital] where blood test was completed faxed over a list of medications that could cause a false positive PCP test. One of [client B's] medications [Lamictal] is on that list...The [name of RN] placed a call to [Name of client B's physician] requesting statement verifying [Lamictal] can cause a false positive, [name of doctor] refused." On 9/15/16 at 8:25am, client B's 4/27/16 Hospital ER record was reviewed. Client B's 4/27/16 "Physician's Notes" which indicated "Pt. (Patient) brought from group home for evaluation after seizure. Per caregiver, this was his normal			

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	convulsive seizure and he has them weekly. It is unclear whether Pt. hit his head, as staff initially states to triage there was no head injury then tells nursing staff he did hit his head. Caregiver and Pt. both deny head injury to me. Pt. states to RN and myself in private conversations that Pt. is becoming increasingly more aggressive toward himself and toward staff. They question if he has been using illicit drugs as he has a hx. (history) of this. Caregiver reports he was banging his head against the wall yesterday, hitting his knuckles together, and is acting overall more drowsy and fatigued." No repeat drug screen labs were completed. On 9/15/16 at 11:00am, an interview with the Residential Manager (RM) was conducted. The RM stated the facility staff "never have searched" client B's room. After the 4/27/16 positive drug test indicated PCP, client B threatened physical aggression toward the staff "if they searched his person or his room." The RM stated client B attended NA meetings from 1/2016 through 4/21/16 "two to three times a week." The RM stated client B "has not attended since 4/21/16." The RM indicated the staff offer to take him and client B refuses to attend.			

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	On 9/16/16 at 3:00pm, an interview with the agency RN (Registered Nurse) was conducted. The RN stated client B was seen in the ER on 4/27/16 after banging his head on a wall which caused a seizure and he "was acting erratically and being emotionally not himself." The RN stated client B "had a history of drug abuse, using illegal substances, and given his behavior I called the ER and requested a drug screen" be completed. The RN indicated she reviewed lab results when the hospital sent the results to the facility. The RN indicated client B was prescribed Lamictal medication for his seizures and the medication was one of the 18 listed medications which "could have caused a false positive result" for the drug screen. The RN stated she did not know if client B's positive result for PCP was the result of the medication or "if" client B had consumed PCP. The RN stated client B's physician did not repeat the drug screen to determine if the lab results were accurate or a "false positive" for PCP. The RN indicated client B's history for the use of illegal drug use, alcohol abuse, and the fact he attended NA meetings where he would have been exposed to other users of the illegal substances she was unable to rule out the possibility of his use. The RN indicated client B had stopped attending NA meetings after 4/21/16.			

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	On 9/15/16 at 9:15am, on 9/15/16 at 12:15pm, and on 9/16/16 at 10am, client B's therapeutic leave sign in/sign out sheets which would have indicated when he left the group home with a visitor were requested and none was provided. On 9/15/16 at 11:00am, an interview was conducted with the Area Director (AD) and the PC/QIDP (Program Coordinator/Qualified Intellectual Disabilities Professional). Both professional staff indicated the facility followed the BDDS reporting policy and procedure. The AD stated the 4/27/16 "Risk Management Peer Review" was what the agency considered to be their investigation. The AD indicated the agency had IDT meetings documented on "T-Logs" in client B's record. The AD indicated the Peer Review and the T-Logs did not include checks of the environment, completed interviews with staff and clients, review of client B's records, and was not a thorough investigation. Both professional staff indicated the agency was notified on 4/27/16 of client B's positive results for PCP an illegal substance. Both professional staff indicated client B's positive illegal drug result was reported to BDDS and the AD stated "there was no formal investigation" completed. The			

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	AD stated the agency held an IDT on 4/28/16 after the ER visit which indicated the notification of the events before the ER and the positive drug test. On 9/15/16 at 11:00am, the PC/QIDP and the AD both stated client B had gone on therapeutic leaves in the community "with people he met in NA meetings and had returned to the facility intoxicated." The PC/QIDP stated on "8/15/16 at 5:50pm" she received a text message stating "a can of unopened beer" had been located behind the wheel of the facility van on the parking lot. The PC/QIDP and the AD indicated the staff believed the beer was left by client B's friends for client B. The PC/QIDP stated client B had been "drunk" (intoxicated) on 8/1/16. The PC/QIDP indicated he mixed beer with an energy drink when on therapeutic leave with his family. The AD stated client B did not have a guardian and "has the right to consume alcohol" if client B wants. Both professional staff indicated client B was on medications for his behaviors and for seizures and the AD stated "It is not a good idea to drink, but we can't stop him." The PC/QIDP and the AD both indicated no written investigation was available for review. When asked given client A's positive lab results for THC on 4/21/16 and client B's positive lab results			

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	for PCP on 4/28/16 was there a pattern identified which would have indicated a potential problem in which an investigation of some type would have generated the agency staff to talk with the staff and the clients regarding illegal drug activity and drugs at the group home, the AD indicated an investigation should have been completed. The AD indicated no witness statements, no review outside of the nurse of client B's medical records, no check of the environment, and no repeat drug screen was completed. The AD stated "We had an IDT." 3. On 9/14/16 at 2:30pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed for the period from 4/1/16 through 9/14/16 and indicated the following for clients F and G: -A 4/28/16 BDDS report for an incident on 4/16/16 at 12:00pm indicated clients F and G "stated that [name of GHS (Group Home Staff) #11] yelled at them and told them to shut up. A fellow staff called and told her supervisor on 4/20/16 [name of Residential Manager] and stated that [GHS #11] had a rude tone with the clients but did not state she had told the clients to shut up. Investigation was completed and found that [GHS #11] did not tell clients to shut up," returned to			

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	work on 4/30/16, and "will be retrained" on "appropriate tone of voice...." -The 4/22/16 "Summary of Internal Investigation" indicated paraphrased witness statements, no narrative witness statements, no questions asked, and no retraining for immediate reporting was available for review. The investigation indicated "Evidence supports [clients F and G] report [GHS #11] has told them to shut up. Evidence supports [GHS #11's] co-workers describe her interactions as rude. Evidence supports [GHS #11] does not use appropriate tone and approach with clients or co-workers...." The investigation indicated GHS #11 would be retrained. On 9/15/16 at 11:00am, the PC/QIDP and the AD both indicated the investigation into clients F and G's allegation included paraphrased witness statements, no narrative witness statements, no questions asked, and no retraining for immediate reporting was available for review. The AD indicated GHS #11 was suspended from 4/20/16 until the investigation was completed. The AD indicated allegations should be immediately reported and thoroughly investigated. The AD indicated no further information was available for review.			

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	The facility's policy and procedures were reviewed on 9/15/16 at 12:15pm. The facility's 4/2011 Quality and Risk Management policy indicated "Indiana Mentor promotes a high quality of service and seeks to protect individuals receiving Indiana Mentor services through oversight of management procedures and company operations, close monitoring of service delivery and through a process of identifying, evaluating and reducing risk to which individuals are exposed." The 4/2011 Quality and Risk Management Policy indicated failure to provide appropriate supervision, care or training was considered neglect. The 4/2011 Quality and Risk Management Policy indicated, "Indiana Mentor is committed to completing a thorough investigation for any event out of the ordinary which jeopardizes the health and safety of any individual served or other employee. (1.) Investigation findings will be submitted to the AD (Area Director) for review and development of further recommendations as needed within 5 days of the incident." On 9/15/16 at 12:15pm, a record review was conducted of the 10/2005 "Bureau of Developmental Disabilities Services Policy and Guidelines." The BDDS policy and procedure indicated "...Abuse,			

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(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
	Neglect, and Mistreatment of Individuals...it is the policy of the company to ensure that individuals are not subjected to physical, verbal, sexual, or psychological abuse or exploitation by anyone including but not limited to: facility staff...other individuals, or themselves." The policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs although sources of such support are available and offered and such failure results in physical or psychological harm to the individual." The BDDS policy indicated each allegation of abuse, neglect, and/or mistreatment should be immediately reported. On 9/15/16 at 12:15pm, the 4/2003 "Reportable Incidents to the Bureau of Developmental Disabilities Services" indicated "Reportable incidents area any event characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to an individual or death of an individual." This federal tag relates to complaint #IN00200306. 9-3-2(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	15G735		09/20/2016

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REM OCCAZIO LLC	1206 S MAIN ST NEW CASTLE, IN 47362

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W 0153 Bldg. 00	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on interview and record review, for 1 of 20 BDDS (Bureau of Developmental Disabilities Services) reports reviewed (client B) and 1 additional report (client A), the facility failed to immediately and accurately report allegations of clients A and B's positive laboratory (lab) results for the use of illegal drugs to the administrator, and state officials (Bureau of Developmental Disabilities Services-BDDS 9-3-1(b)(5), and/or Adult Protective Services -APS) IC 12-10-3 in accordance with state law. Findings include: 1. On 9/14/16 at 2:30pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed for the period from 4/1/16 through 9/14/16 and indicated the following for client A: -A 4/22/16 BDDS report for an incident on 4/21/16 at 7:45pm indicated client A was seen in the emergency room (ER) for	W 0153	**W153 Staff Treatment of Clients** The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. **1. What corrective action will be accomplished?** •□□□□□□□□ Staff, Program Coordinator and Program Director (QIDP) will be retrained on reporting and documenting all incidents of possible illegal drug use. •□□□□□□□□ Program Director will be retrained on investigation protocol and timeliness for incidents of possible illegal drug use. •□□□□□□□□ Monthly, the facility nurse, Program Coordinator and Program Director (QIDP) will meet to review client needs, all client care, incidents and risk plans to ensure client safety. **2. How will we identify other residents having the potential**	10/20/2016

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	a seizure. The report indicated client A's "blood work" was "within normal limits." The report did not indicate she had a positive laboratory (lab) result for "THC (Tetrahydrocannabinol also known as the active chemical in marijuana). The positive THC was not reported to BDDS, the administrator, and APS. Client A's record was reviewed on 9/15/16 at 10:30am and on 9/16/16 at 9:30am. Client A's 4/21/16 at 7:52am, a "Family and Internal Medicine" physician's visit did not include the diagnosis of seizure disorder. Client A's 5/17/16 "Nursing Progress Note" indicated on "4/21/16 [client A] was seen at [name of hospital ER] (sic) following seizure, drug screen was completed in ER showing P (Positive) THC our staff was not made aware of findings @ (at) d/c (discharge from the ER). Reported findings to MD (client A's personal physician) today when writer was made aware." -Client A's 4/21/16 Hospital ER record regarding her visit to the ER indicated she was seen for a seizure. Client A's 4/22/16 Lab results indicated a urine test and "THC Positive." -Client A's 4/26/16 "T-Log (an entry into a client's computerized record)" indicated		**to be affected by the same deficient practice and what corrective action will be taken?** •□□□□□□□□ All residents have the potential to be affected by the same deficient practice. •□□□□□□□□ Staff, Program Coordinator and Program Director (QIDP) will be retrained on reporting and documenting all incidents of possible illegal drug use. •□□□□□□□□ Program Director will be retrained on investigation protocol and timeliness for incidents of possible illegal drug use. •□□□□□□□□ Monthly, the facility nurse, Program Coordinator and Program Director (QIDP) will meet to review client needs, all client care, incidents and risk plans to ensure client safety. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** •□□□□□□□ Staff, Program Coordinator and Program Director (QIDP) will be retrained on reporting and documenting all incidents of possible illegal drug use. •□□□□□□□ Program Director will be retrained on investigation protocol and timeliness for incidents of possible illegal drug use.	

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	client A was seen for a seizure at the ER and a follow up appointment was scheduled for 5/11/16. Client A's 4/26/16 "T-Log" indicated her medication "Divalproex (for intermittent explosive disorder) 375mg (milligrams) at 5:00pm remained the same" and her Divalproex 250mg was increased from 250mg to 500mg at 8:00am. -Client A's 4/26/16 "T-Log" indicated she received the Divalproex for intermittent explosive disorder and "not for seizures. [Client A] did not have a diagnosis of Seizure Disorder" and an appointment was made with a neurologist. -Client A's 5/17/16 "T-Log" indicated "IDT (Interdisciplinary Team): Positive THC drug screen. Description: Discussion [client A] went to a (sic) appointment on 4/21 and was told that when [client A] went to the ER visit at [name of hospital] ER doctor implemented a drug screen that came back positive for THC drug." The T-Log indicated the agency nurse was reviewing client A's medications which could have caused "a false-positive" drug screen result for THC. On 9/16/16 at 3:00pm, an interview with the agency RN (Registered Nurse) was conducted. The RN indicated client A		•□□□□□□□ Monthly, the facility nurse, Program Coordinator and Program Director (QIDP) will meet to review client needs, all client care, incidents and risk plans to ensure client safety. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** •□□□□□□□ Staff, Program Coordinator and Program Director (QIDP) will be retrained on reporting and documenting all incidents of possible illegal drug use. •□□□□□□□ Program Director will be retrained on investigation protocol and timeliness for incidents of possible illegal drug use. •□□□□□□□ Monthly, the facility nurse, Program Coordinator and Program Director (QIDP) will meet to review client needs, all client care, incidents and risk plans to ensure client safety. **5. What is the date by which the systemic changes will be completed?** **10/20/16**	

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	was seen in the ER for a seizure on 4/21/16 and a drug screen was completed. The RN indicated the staff who took client A to the ER and the hospital indicated client A's labs were within normal limits. The RN indicated she received a call after the client was seen by the doctor on 5/11/16 for a follow up appointment after the 4/21/16 ER visit and the doctor told the staff and client A about the positive drug results. The RN indicated she was not aware of the positive THC result before 5/17/16 when she was notified by the staff. The RN indicated she reviewed lab results when the hospital sent the results and the hospital had sent the results of the 4/21/16 ER visit to the doctor and not to the facility. The RN stated client A received routine medications for her Osteoarthrosis, "anti inflammatory medications," and "Gout (a disorder of the muscles characterized by severe pain)" which "could have caused a false positive lab result." The RN stated the medications that "could possibly cause a false positive" were "Allopurinol (for Gout and muscle pain), Colcrys (for Gout and muscle pain), Nabumetone (used to reduce pain and joint stiffness), and Prednisone (used to decrease inflammation)." The RN indicated she did not know if client A's positive THC lab result was reported to BDDS, the			

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	Administrator, and APS. The RN indicated client A's physician did not repeat the drug screen to determine if the lab results were accurate or a "false positive" for THC. The RN indicated client A would not identify illegal drugs and was not known to have a history of positive lab results for illegal drugs. The RN indicated client A was admitted on 4/20/15 and had routine labs completed by her doctor. On 9/15/16 at 11:00am, an interview was conducted with the Area Director (AD) and the PC/QIDP (Program Coordinator/Qualified Intellectual Disabilities Professional). Both professional staff indicated the facility followed the BDDS reporting policy and procedure. Both professional staff indicated the agency was notified on 5/11/16 during a medical follow up appointment with client A's physician that the drug screen completed on 4/21/16 was positive for THC and the agency nurse was notified on 5/17/16 by the facility staff. Both professional staff indicated client A's positive illegal drug result was not reported to BDDS. The AD stated the agency held an IDT on 5/17/16 with the agency nurse and she concluded that client A was receiving routine medications which could have caused a "false positive result." When			

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	asked if the agency reported allegations and possible criminal activity, the AD indicated client A's positive lab results should have been immediately reported. 2. On 9/14/16 at 2:30pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed for the period from 4/1/16 through 9/14/16 and indicated the following for client B: -A 4/28/16 BDDS report for an incident on 4/27/16 at 2:00pm indicated client B's workshop staff "reported that [client B] was engaging in SIB (Self Injurious Behavior) as evidenced by banging (his) head on the wall. [Client B] then had a seizure. Client currently has a seizure diagnosis. Seizures are currently uncontrolled. Client has a VNS (Vagus Nerve Stimulator) magnet (used to interrupt seizure activity). Group Home staff picked client up and transported [client B] to [name of hospital] ER for evaluation. During ER examination, doctor completed a routine drug screen. Preliminary unconfirmed results suggested client was positive for PCP (Phencyclidine also known as angel dust, an addictive illegal drug that causes hallucinations and produces feelings of detachment). [Name of Behavior Health Service] completed evaluation, stating			

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	[client B] was not a threat to himself or others. Client was returned to group home. IDT called emergency meeting 4/28/16. Full investigation will be completed by QI (Quality Internal). Immediate protective measures were put in place including locking chemicals. One on one staffing during waking hours, line of sight supervision during Narcotics Anonymous (NA) meetings, advocating for inpatient rehabilitation, therapeutic leaves are temporarily on hold, exploring alternatives for NA meetings (NA) meetings are possible source for drugs, considering formal programming to help client identify risks of drug use...." -A 4/28/16 "Follow Up" BDDS report indicated client B was "in good health at this time. The investigation has proven that [client B] tested a false positive for PCP because he currently takes Lamictal 300mg medication which is one of the 18 drugs that will make a person test a false positive for PCP. An IDT meeting was held today and [client B's] safety and health was the topics (sic). [Client B] will be in the line of sight supervision when in the community being referred to a psychiatrist for mental health assessment...." -A 4/27/16 "Risk Management Peer Review" indicated client B had SIB at the			

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	day program, banged his head on the wall, had a seizure, and was transported to the local hospital ER for evaluation. Client B's record was reviewed on 9/15/16 at 11:15am and on 9/16/16 at 1:45pm. Client B's 1/21/16 ISP (Individual Support Plan) and 4/28/16 BSP (Behavior Support Plan) both indicated client B "has been arrested for battery as juvenile, public intoxication and resisting law enforcement as an adult. [Client B] has a long history of alcohol abuse normally 1/2 gallon of liquor or 1/2 case of beer per incident. [Client B] also has a substance abuse issue with marijuana and he smokes regularly...[Client B] states he used Crystal Meth and Crack Cocaine several years ago but no longer has issues with those substances." -Client B's 4/28/16 "T-Log" indicated "IDT met at 9am (sic)...Behaviors he exhibited at [name of workshop]...was engaging in verbal aggression and SIB (Self Injurious Behavior) head butting the wall. [Client B] was upset because his mother lied to him about what he could and could not do living with [the group home name]. After [client B] head butted the wall he had a tonic clonic seizure and was not injured. [Name of Agency Registered Nurse] requested			

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	[client B] go to ER. ER checked [client B's] health status and also done a urine and blood test for drugs. [Client B] had a false positive reading for PCP because he takes Lamictal medication...." -Client B's 5/16/16 "T-Log" indicated client B's physician was notified on 5/15/16 by the RN to request a statement from client B's physician to indicate client B "had a drug screen that showed a positive PCP result. Lab at [name of hospital] where blood test was completed faxed over a list of medications that could cause a false positive PCP test. One of [client B's] medications [Lamictal] is on that list...The [name of RN] placed a call to [Name of client B's physician] requesting statement verifying [Lamictal] can cause a false positive, [name of doctor] refused." On 9/15/16 at 8:25am, client B's 4/27/16 Hospital ER record was reviewed. Client B's 4/27/16 "Physician's Notes" which indicated "Pt. (Patient) brought from group home for evaluation after seizure. Per caregiver, this was his normal convulsive seizure and he has them weekly. It is unclear whether Pt. hit his head, as staff initially states to triage there was no head injury then tells nursing staff he did hit his head. Caregiver and Pt. both deny head injury			

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	to me. Pt. states to RN and myself in private conversations that Pt. is becoming increasingly more aggressive toward himself and toward staff. They question if he has been using illicit drugs as he has a hx. (history) of this. Caregiver reports he was banging his head against the wall yesterday, hitting his knuckles together, and is acting overall more drowsy and fatigued." On 9/16/16 at 3:00pm, an interview with the agency RN (Registered Nurse) was conducted. The RN stated client B was seen in the ER on 4/27/16 after banging his head on a wall which caused a seizure "was acting erratically and being emotionally not himself." The RN stated client B "had a history of drug abuse, using illegal substances, and given his behavior I called the ER and requested a drug screen" be completed. The RN indicated she reviewed lab results when the hospital sent the results to the facility. The RN indicated client B was prescribed Lamictal medication for his seizures and the medication was one of the 18 listed medications which "could have caused a false positive result" for the drug screen. The RN indicated she did not know if client B's positive result for PCP lab result was the result of the medication or "if" client B had consumed PCP. The RN indicated client B's physician did not			

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	repeat the drug screen to determine if the lab results were accurate or a "false positive" for PCP. The RN indicated client B's history for the use of illegal drug use, alcohol abuse, and the fact he attended NA meetings where he would have been exposed to other users of the illegal substances she was unable to rule out the possibility of his use. The RN indicated client B had stopped attending NA meetings after 4/21/16. On 9/15/16 at 11:00am, an interview was conducted with the Area Director (AD) and the PC/QIDP (Program Coordinator/Qualified Intellectual Disabilities Professional). Both professional staff indicated the facility followed the BDDS reporting policy and procedure. The AD stated the 4/27/16 "Risk Management Peer Review" was what the agency considered to be their investigation. The AD indicated the agency had IDT meetings documented on "T-Logs" in client B's record. Both professional staff indicated the agency was notified on 4/27/16 of client B's positive lab drug screen results for PCP an illegal substance. Both professional staff indicated client B's positive illegal drugs result was reported to BDDS. The AD stated the agency held an IDT on 4/28/16 after the ER visit which indicated the notification of the events before the			

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	ER and the positive drug test. This federal tag relates to complaint #IN00200306. 9-3-2(a)			
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 interview and record review, for 2 of 2 allegations of abuse, neglect, and/or mistreatment reviewed for 2 of 3 sample clients (clients A and B) and for 2 additional clients (clients F and G), the facility failed to thoroughly investigate allegations of abuse, neglect, and/or mistreatment and allegations regarding clients A and B's positive laboratory (lab) results of illegal drugs and clients F and G's allegation of unsubstantiated staff abuse. Findings include: 1. On 9/14/16 at 2:30pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed for the period from 4/1/16 through 9/14/16 and indicated the following for client A:	W 0154	**W154 Staff Treatment of Clients** The facility must ensure that all alleged violations are thoroughly investigated. **1. What corrective action will be accomplished?** •□□□□□□□□ Staff, Program Coordinator and Program Director (QIDP) will be retrained on reporting and documenting all incidents of possible illegal drug use. •□□□□□□□□ Program Director will be retrained on investigation protocol and timeliness for incidents of possible illegal drug use. •□□□□□□□□ Monthly, the facility nurse, Program Coordinator and Program Director (QIDP) will meet to review client needs, all client care, incidents and risk plans to ensure client safety.	10/20/2016

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	-A 4/22/16 BDDS report for an incident on 4/21/16 at 7:45pm indicated client A was seen in the emergency room (ER) for a seizure. The report indicated client A's "blood work" was "within normal limits." The report did not indicate she had a positive laboratory (lab) result for "THC (Tetrahydrocannabinol also known as the active chemical in marijuana). No investigation for the positive THC was available for review. Client A's record was reviewed on 9/15/16 at 10:30am and on 9/16/16 at 9:30am. Client A's 4/21/16 at 7:52am, "Family and Internal Medicine" physician's visit did not include the diagnosis of seizure disorder. Client A's 5/17/16 "Nursing Progress Note" indicated on "4/21/16 [client A] was seen at [name of hospital ER] (sic) following seizure, drug screen was completed in ER showing P (Positive) THC our staff was not made aware of findings @ (at) d/c (discharge from the ER). Reported findings to MD (client A's personal physician) today when writer was made aware." -Client A's 4/21/16 Hospital ER record regarding her visit to the ER indicated she was seen for a seizure. Client A's 4/22/16 Lab results indicated a urine test and "THC Positive."		**2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** •□□□□□□□□ All residents have the potential to be affected by the same deficient practice. •□□□□□□□□ Staff, Program Coordinator and Program Director (QIDP) will be retrained on reporting and documenting all incidents of possible illegal drug use. •□□□□□□□□ Program Director will be retrained on investigation protocol and timeliness for incidents of possible illegal drug use. •□□□□□□□□ Monthly, the facility nurse, Program Coordinator and Program Director (QIDP) will meet to review client needs, all client care, incidents and risk plans to ensure client safety. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** •□□□□□□□ Staff, Program Coordinator and Program Director (QIDP) will be retrained on reporting and documenting all incidents of possible illegal drug use. •□□□□□□□ Program Director will be retrained on investigation	

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	-Client A's 4/26/16 "T-Log (an entry into a client's computerized record)" indicated client A was seen for a seizure at the ER and a follow up appointment was scheduled for 5/11/16. Client A's 4/26/16 "T-Log" indicated her medication "Divalproex (for intermittent explosive disorder) 375mg (milligrams) at 5:00pm remained the same" and her Divalproex 250mg was increased from 250mg to 500mg at 8:00am. -Client A's 4/26/16 "T-Log" indicated she received the Divalproex for intermittent explosive disorder and "not for seizures. [Client A] did not have a diagnosis of Seizure Disorder" and an appointment was made with a neurologist. -Client A's 5/17/16 "T-Log" indicated "IDT (Interdisciplinary Team): Positive THC drug screen. Description: Discussion [client A] went to a (sic) appointment on 4/21 and was told that when [client A] went to the ER visit at [name of hospital] ER doctor implemented a drug screen that came back positive for THC drug." The T-Log indicated the agency nurse was reviewing client A's medications which could have caused "a false-positive" drug screen result for THC.		protocol and timeliness for incidents of possible illegal drug use. •□□□□□□□ Monthly, the facility nurse, Program Coordinator and Program Director (QIDP) will meet to review client needs, all client care, incidents and risk plans to ensure client safety. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** •□□□□□□□ Staff, Program Coordinator and Program Director (QIDP) will be retrained on reporting and documenting all incidents of possible illegal drug use. •□□□□□□□ Program Director will be retrained on investigation protocol and timeliness for incidents of possible illegal drug use. •□□□□□□□ Monthly, the facility nurse, Program Coordinator and Program Director (QIDP) will meet to review client needs, all client care, incidents and risk plans to ensure client safety. **5. What is the date by which the systemic changes will be completed?** **10/20/16**	

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	On 9/16/16 at 3:00pm, an interview with the agency RN (Registered Nurse) was conducted. The RN indicated client A was seen in the ER for a seizure on 4/21/16 and a drug screen was completed. The RN indicated the staff who took client A to the ER and the hospital indicated client A's labs were within normal limits. The RN indicated she received a call after the client was seen by the doctor on 5/11/16 for a follow up appointment after the 4/21/16 ER visit and the doctor told the staff and client A about the positive drug results. The RN indicated she was not aware of the positive THC result before 5/17/16 when she was notified by the staff. The RN indicated she reviewed lab results when the hospital sent the results and the hospital had sent the results of the 4/21/16 ER visit to the doctor and not to the facility. The RN stated client A received routine medications for her Osteoarthrosis, "anti inflammatory medications," and "Gout (a disorder of the muscles characterized by severe pain)" which "could have caused a false positive lab result." The RN stated the medications that "could possibly cause a false positive" were "Allopurinol (for Gout and muscle pain), Colcrys (for Gout and muscle pain), Nabumetone (used to reduce pain and joint stiffness), and Prednisone (used to decrease			

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	inflammation)." The RN indicated she did not know if client A's positive THC lab result was investigated. The RN indicated client A's physician did not repeat the drug screen to determine if the lab results were accurate or a "false positive" for THC. The RN indicated client A would not identify illegal drugs and was not known to have a history of positive lab results for illegal drugs. The RN indicated client A was admitted on 4/20/15 and had routine labs completed by her doctor. On 9/15/16 at 11:00am, an interview was conducted with the Area Director (AD) and the PC/QIDP (Program Coordinator/Qualified Intellectual Disabilities Professional). Both professional staff indicated the agency was notified on 5/11/16 during a medical follow up appointment with client A's physician that the drug screen completed on 4/21/16 was positive for THC and the agency nurse was notified on 5/17/16 by the facility staff. The AD stated "there was no formal investigation" completed of client A's positive lab result. The AD stated the agency held an IDT on 5/17/16 with the agency nurse and she concluded that client A was receiving routine medications which could have caused a "false positive result." The AD indicated no witness statements, no review outside			

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	of the nurse of client A's medical records, no check of the environment, and no repeat drug screen were completed. The AD stated "We had an IDT." The AD indicated client A's positive lab results should have been investigated. 2. On 9/14/16 at 2:30pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed for the period from 4/1/16 through 9/14/16 and indicated the following for client B: -A 4/28/16 BDDS report for an incident on 4/27/16 at 2:00pm indicated client B's workshop staff "reported that [client B] was engaging in SIB (Self Injurious Behavior) as evidenced by banging (his) head on the wall. [Client B] then had a seizure. Client currently has a seizure diagnosis. Seizures are currently uncontrolled. Client has a VNS (Vagus Nerve Stimulator) magnet (used to interrupt seizure activity). Group Home staff picked client up and transported [client B] to [name of hospital] ER for evaluation. During ER examination, doctor completed a routine drug screen. Preliminary unconfirmed results suggested client was positive for PCP (Phencyclidine also known as angel dust, an addictive illegal drug that causes hallucinations and produces feelings of			

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	detachment). [Name of Behavior Health Service] completed evaluation, stating [client B] was not a threat to himself or others. Client was returned to group home. IDT called emergency meeting 4/28/16. Full investigation will be completed by QI (Quality Internal). Immediate protective measures were put in place including locking chemicals. One on one staffing during waking hours, line of sight supervision during Narcotics Anonymous (NA) meetings, advocating for inpatient rehabilitation, therapeutic leaves are temporarily on hold, exploring alternatives for NA meetings (NA) meetings are possible source for drugs, considering formal programming to help client identify risks of drug use...." The report did not include an investigation. -A 4/28/16 "Follow Up" BDDS report indicated client B was "in good health at this time. The investigation has proven that [client B] tested a false positive for PCP because he currently takes Lamictal 300mg medication which is one of the 18 drugs that will make a person test a false positive for PCP. An IDT meeting was held today and [client B's] safety and health was the topics (sic). [Client B] will be in the line of sight supervision when in the community being referred to a psychiatrist for mental health assessment...." The report did not			

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	include an investigation. -A 4/27/16 "Risk Management Peer Review" indicated client B had SIB at the day program, banged his head on the wall, had a seizure, and was transported to the local hospital ER for evaluation. The review did not include a documented investigation regarding client B's positive PCP drug screen results, physician notification, interviews with clients and staff, client B's documents reviewed, client B's known history of drug addiction, client B's activities outside the group home, client B's LOA's (Leaves of Absence), client B's current medications, and community supports reviewed. No investigation was available for review. Client B's record was reviewed on 9/15/16 at 11:15am and on 9/16/16 at 1:45pm. Client B's 1/21/16 ISP (Individual Support Plan) and 4/28/16 BSP (Behavior Support Plan) both indicated client B "has been arrested for battery as juvenile, public intoxication and resisting law enforcement as an adult. [Client B] has a long history of alcohol abuse normally 1/2 gallon of liquor or 1/2 case of beer per incident. [Client B] also has a substance abuse issue with marijuana and he smokes regularly...[Client B] states he used Crystal Meth and Crack Cocaine several			

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	years ago but no longer has issues with those substances." -Client B's 4/28/16 "T-Log" indicated "IDT met at 9am (sic)...Behaviors he exhibited at [name of workshop]...was engaging in verbal aggression and SIB (Self Injurious Behavior) head butting the wall. [Client B] was upset because his mother lied to him about what he could and could not do living with [the group home name]. After [client B] head butted the wall he had a tonic clonic seizure and was not injured. [Name of Agency Registered Nurse] requested [client B] go to ER. ER checked [client B's] health status and also done (sic) a urine and blood test for drugs. [Client B] had a false positive reading for PCP because he takes Lamictal medication...." -Client B's 5/16/16 "T-Log" indicated client B's physician was notified on 5/15/16 by the RN to request a statement from client B's physician to indicate client B "had a drug screen that showed a positive PCP result. Lab at [name of hospital] where blood test was completed faxed over a list of medications that could cause a false positive PCP test. One of [client B's] medications [Lamictal] is on that list...The [name of RN] placed a call to [Name of client B's physician] requesting statement verifying			

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	[Lamictal] can cause a false positive, [name of doctor] refused." On 9/15/16 at 8:25am, client B's 4/27/16 Hospital ER record was reviewed. Client B's 4/27/16 "Physician's Notes" which indicated "Pt. (Patient) brought from group home for evaluation after seizure. Per caregiver, this was his normal convulsive seizure and he has them weekly. It is unclear whether Pt. hit his head, as staff initially states to triage there was no head injury then tells nursing staff he did hit his head. Caregiver and Pt. both deny head injury to me. Pt. states to RN and myself in private conversations that Pt. is becoming increasingly more aggressive toward himself and toward staff. They question if he has been using illicit drugs as he has a hx. (history) of this. Caregiver reports he was banging his head against the wall yesterday, hitting his knuckles together, and is acting overall more drowsy and fatigued." No repeat drug screen labs were completed. On 9/15/16 at 11:00am, an interview with the Residential Manager (RM) was conducted. The RM stated the facility staff "never have searched" client B's room. After the 4/27/16 positive drug test indicated PCP, client B threatened physical aggression toward the staff "if			

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	they searched his person or his room." The RM stated client B attended NA meetings from 1/2016 through 4/21/16 "two to three times a week." The RM stated client B "has not attended since 4/21/16." The RM indicated the staff offer to take him and client B refuses to attend. On 9/16/16 at 3:00pm, an interview with the agency RN (Registered Nurse) was conducted. The RN stated client B was seen in the ER on 4/27/16 after banging his head on a wall which caused a seizure and he "was acting erratically and being emotionally not himself." The RN stated client B "had a history of drug abuse, using illegal substances, and given his behavior I called the ER and requested a drug screen" be completed. The RN indicated she reviewed lab results when the hospital sent the results to the facility. The RN indicated client B was prescribed Lamictal medication for his seizures and the medication was one of the 18 listed medications which "could have caused a false positive result" for the drug screen. The RN stated she did not know if client B's positive result for PCP was the result of the medication or "if" client B had consumed PCP. The RN stated client B's physician did not repeat the drug screen to determine if the lab results were accurate or a "false positive" for PCP.			

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	The RN indicated client B's history for the use of illegal drug use, alcohol abuse, and the fact he attended NA meetings where he would have been exposed to other users of the illegal substances she was unable to rule out the possibility of his use. The RN indicated client B had stopped attending NA meetings after 4/21/16. On 9/15/16 at 9:15am, on 9/15/16 at 12:15pm, and on 9/16/16 at 10am, client B's therapeutic leave sign in/sign out sheets which would have indicated when he left the group home with a visitor were requested and none was provided. On 9/15/16 at 11:00am, an interview was conducted with the Area Director (AD) and the PC/QIDP (Program Coordinator/Qualified Intellectual Disabilities Professional). The AD stated the 4/27/16 "Risk Management Peer Review" was what the agency considered to be their investigation. The AD indicated the agency had IDT meetings documented on "T-Logs" in client B's record. The AD indicated the Peer Review and the T-Logs did not include checks of the environment, completed interviews with staff and clients, review of client B's records, and was not a thorough investigation. Both professional staff indicated the agency			

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	was notified on 4/27/16 of client B's positive results for PCP an illegal drugs. The AD stated "there was no formal investigation" completed. The AD stated the agency held an IDT on 4/28/16 after the ER visit which indicated the notification of the events before the ER and the positive drug test. On 9/15/16 at 11:00am, the PC/QIDP and the AD both stated client B had gone on therapeutic leaves in the community "with people he met in NA meetings and had returned to the facility intoxicated." The PC/QIDP stated on "8/15/16 at 5:50pm" she received a text message stating "a can of unopened beer" had been located behind the wheel of the facility van on the parking lot. The PC/QIDP and the AD indicated the staff believed the beer was left by client B's friends for client B. The PC/QIDP stated client B had been "drunk" (intoxicated) on 8/1/16. The PC/QIDP indicated he mixed beer with an energy drink when on therapeutic leave with his family. The AD stated client B did not have a guardian and "has the right to consume alcohol" if client B wants. Both professional staff indicated client B was on medications for his behaviors and for seizures and the AD stated "It is not a good idea to drink, but we can't stop him." The PC/QIDP and the AD both			

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	indicated no written investigation was available for review. When asked given client A's positive lab results for THC on 4/21/16 and client B's positive lab results for PCP on 4/28/16 was there a pattern identified which would have indicated a potential problem in which an investigation of some type would have generated the agency staff to talk with the staff and the clients regarding illegal drug activity and drugs at the group home, the AD indicated an investigation should have been completed and was not. The AD indicated no witness statements, no review outside of the nurse of client B's medical records, no check of the environment, and no repeat drug screen was completed. The AD stated "We had an IDT." 3. On 9/14/16 at 2:30pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed for the period from 4/1/16 through 9/14/16 and indicated the following for clients F and G: -A 4/28/16 BDDS report for an incident on 4/16/16 at 12:00pm indicated clients F and G "stated that [name of GHS (Group Home Staff) #11] yelled at them and told them to shut up. A fellow staff called and told her supervisor on 4/20/16 [name of Residential Manager] and stated that			

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	[GHS #11] had a rude tone with the clients but did not state she had told the clients to shut up. Investigation was completed and found that [GHS #11] did not tell clients to shut up," returned to work on 4/30/16, and "will be retrained" on "appropriate tone of voice...." -The 4/22/16 "Summary of Internal Investigation" indicated paraphrased witness statements, no narrative witness statements, no questions asked, and no retraining for immediate reporting was available for review. The investigation indicated "Evidence supports [clients F and G] report [GHS #11] has told them to shut up. Evidence supports [GHS #11's] co-workers describe her interactions as rude. Evidence supports [GHS #11] does not use appropriate tone and approach with clients or co-workers...." The investigation indicated GHS #11 would be retrained. On 9/15/16 at 11:00am, the PC/QIDP and the AD both indicated the investigation into clients F and G's allegation included paraphrased witness statements, no narrative witness statements, no questions asked, and no retraining for immediate reporting was available for review. The AD indicated GHS #11 was suspended from 4/20/16 until the investigation was completed. The AD			

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	indicated allegations should be immediately reported and thoroughly investigated. The AD indicated no further information was available for review. This federal tag relates to complaint #IN00200306. 9-3-2(a)			
W 0249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION 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. Based on observation, record review, and interview for 1 additional client (client H), the facility failed to ensure client H was supervised according to her identified needs. Findings include: On 9/14/16 from 4:45pm until 6:15pm, clients A, B, C, D, E, F, G, and H were observed at the group home. During the observation period the silverware drawer was locked. At 5:25pm, client G set the table and asked GHS (Group Home Staff)	W 0249	**W 249 PROGRAM IMPLEMENTATION** 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. **1. What corrective action will be accomplished?**	10/20/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 09/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM OCCAZIO LLC	1206 S MAIN ST NEW CASTLE, IN 47362

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	#7 to use her keys to unlock the drawer to obtain spoons and forks. At 5:25pm, GHS #7 stated "all sharp objects" had to be kept locked because clients B, D, and H had hurt themselves. From 4:45pm until 6:15pm, the facility's food processor with the three sharp exposed blades sat on the counter top at eye level and was not secured. At 5:35pm, GHS #7 indicated the sharp exposed blades of the food processor were considered a sharp and should have been locked up. On 9/16/16 at 11:30am, a review of client H's 3/1/16 ISP (Individual Support Plan) and 2/25/16 BSP (Behavior Support Plan) was conducted. Both records indicated client H had self injurious behavior, physical aggression, and required sharp objects to be kept locked to protect client H and the other clients and staff from client H's behaviors. On 9/15/16 at 11:00am, an interview was conducted with the Area Director (AD) and the PC/QIDP (Program Coordinator/Qualified Intellectual Disabilities Professional). Both professional staff stated client H "required" locked sharp objects and not clients B and D. The AD indicated client H's BSP was not followed to ensure sharp objects were kept locked at the group home.		•□□□□□□□□ Staff will be retrained on implementing client H's ISP and safety concerns with sharps. •□□□□□□□□ Program Coordinator will monitor compliance with ISP and locking sharps through observations, 3 times per week, and ensure all new staff are trained. •□□□□□□□□ Program Director (QIDP) will monitor compliance through BSP and Program documentation, monthly. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** •□□□□□□□□ All residents have the potential to be affected by the same deficient practice •□□□□□□□□ Staff will be retrained on implementing client H's ISP and safety concerns with sharps. •□□□□□□□□ Program Coordinator will monitor compliance with ISP and locking sharps through observations, 3 times per week, and ensure all new staff are trained. •□□□□□□□□ Program Director (QIDP) will monitor compliance through BSP and Program documentation, monthly. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient**	

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NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362	

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	9-3-4(a)		**practice does not recur:** •□□□□□□□ All individual program plans will include continuous active treatment. •□□□□□□□ Staff will be retrained on implementing client H's ISP and safety concerns with sharps. •□□□□□□□ Program Coordinator will monitor compliance with ISP and locking sharps through observations, 3 times per week, and ensure all new staff are trained. •□□□□□□□ Program Director (QIDP) will monitor compliance through BSP and Program documentation, monthly. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** •□□□□□□□ Staff will be retrained on implementing client H's ISP and safety concerns with sharps. •□□□□□□□ Program Coordinator will monitor compliance with ISP and locking sharps through observations, 3 times per week, and ensure all new staff are trained. •□□□□□□□ Program Director (QIDP) will monitor compliance through BSP and Program documentation, monthly. **5. What is the date by which the systemic changes will be completed?**	

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