

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G488	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/15/2014
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NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 38 RYAN DR TRAFALGAR, IN 46181
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: September 8, 9, 10, 12 and 15, 2014.</p> <p>Facility Number: 001002 Provider Number: 15G488 AIMS Number: 100245020</p> <p>Surveyor: Jo Anna Scott, QIDP.</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed September 22, 2014 by Dotty Walton, QIDP.</p>	W000000		
W000159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, record review and interview for 1 of 4 sampled clients (client #1), the QIDP (Qualified Intellectual Disabilities Professional) failed to ensure the nutritional assessment recommendation had been included in the dining plan.</p> <p>Findings include:</p>	W000159	<p>1.What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · Client 1's dining plan updated to include dietary recommendations. · Client 1's MAR updated to reflect dietary recommendations. <p>1.How will we identify other residents having the potential to be affected by the same deficient</p>	10/15/2014

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

TITLE

(X6) DATE

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

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	<p>During the observation period on 9/8/14 from 3:25 PM to 7:00 PM, client #1 ate dinner at 6:10 PM. The meal consisted of a hamburger and okra. The hamburger was broken into small pieces and client #1 ate the hamburger with his fingers. Client #1 did not eat the okra. Client #1 had a Sprite to drink. No supplement was offered.</p> <p>During the observation period on 9/9/14 at 5:30 AM to 8:00 AM, client #1 ate breakfast with the other clients, but staff #5 fed him custodially. Client #1 was not offered a supplement at this meal.</p> <p>The record review for client #1 was conducted on 9/9/14 at 1:38 PM. The nutritional assessment dated 7/8/14 indicated the recommendation of client #1 to receive "1 can Ensure(nutritional supplement) if consumes less than 50% of meal" was to be changed to 1 can of Ensure BID (two times per day).</p> <p>Interview with staff #2, QIDP, on 9/9/14 at 2:00 PM indicated client #1 should be receiving a can of Ensure 2 times a day because of his refusal to eat most food.</p> <p>9-3-3(a)</p>		<p>practice and what corrective action will be taken?</p> <p>Program Director will review dietary assessments of all clients to ensure recommendations have been implemented.</p> <p>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> Staff training regarding Client 1's Dining Plan and MAR. <p>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> Area Director, Program Director and Nurse will review dietary assessments quarterly and monitor to ensure that dining plans are updated as necessary. 				

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W000249	<p>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.</p> <p>Based on observation, record review, and interview for 3 of 4 sampled clients (clients #1, #2 and #4), the facility failed to follow the dining plans.</p> <p>Findings include:</p> <p>1. During the observation period on 9/8/14 from 3:25 PM to 7:00 PM, the evening meal was served at 5:00 PM. The evening meal consisted of ham and beans, Spinach, corn muffin and unsweetened fruit salad. Client #1 did not come to the table until 6:05 PM. Client #1 did have a hamburger broken into pieces with okra on his plate and a sprite to drink; but he did not eat the okra. Client #1 was not offered a supplement.</p> <p>Interview with Staff #2 on 9/8/14 at 6:20 PM indicated client #1 did not like to eat with the other clients and refused to eat what was on the menu. Staff #2 indicated the only things client #1 would</p>	W000249	<p>1.W249 Program Implementation The facility failed to follow the dining plans for Clients 1, 2 and 3.</p> <p>1.What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · Dining Plan for Client 1 updated in regard to receiving Ensure 2x daily and in regard to Client choice of when to eat. · Formal Programming for Client 2 to utilize correct utensils when eating. · Formal Programming for Client 3 in regard to feeding himself. <p>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>Program Director will review dietary assessments of all clients to ensure recommendations have been implemented.</p> <p>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient</p>	10/15/2014			

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	<p>eat were "White Castle" hamburgers, fist sticks and occasionally fish from McDonalds. Staff #2 indicated he refused to eat vegetables or fruit.</p> <p>Review of the dining plan for client #1 was conducted on 9/9/14 at 1:38 PM. The dining plan, undated, indicated client #1 was on a regular diet with chopped meats. The dining plan indicated 1 can of Ensure (nutritional supplement) but did not specify when it was to be given.</p> <p>2. Client #2 ate dinner at 5:00 PM. Client #2 used a regular spoon at dinner.</p> <p>The record review for client #2 was conducted on 9/9/14 at 10:41 AM. The dining plan written 6/12/08 revised January, 2014 indicated adaptive equipment "Baby Spoon."</p> <p>Interview with Administrative staff #2 on 9/10/14 at 10:00 AM indicated client #2 should have used a small bowl spoon.</p> <p>3. Client #4 ate dinner at 5:00 PM with staff sitting beside him, feeding him with a small bowl spoon. Client #4 had a pureed diet with thin liquids.</p> <p>The record review for client #4 was conducted on 9/9/14 at 12:01 PM. The dining plan was dated 4/28/13 and</p>		<p>practice does not recur:</p> <ul style="list-style-type: none"> · Staff training regarding Client 1, 2 and 3's dining plans and dining programming. · Home Manager will conduct a random meal observation weekly. · Home Manager will scan meal observation documentation to Program Director and Area Director upon completion of observation. <p>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · Area Director, Program Director and Nurse will review dietary assessments quarterly and monitor to ensure that dining plans are updated as necessary. · Program Director and Area Director will review meal observations weekly. <p>Addendum to 249W249 Program Implementation The facility failed to follow the dining plans for Clients 1, 2 and 3.</p> <p>1.What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · Dining Plan for Client 1 updated in regard to receiving Ensure 2x daily and in regard to Client choice of when to eat. · Formal Programming for Client 2 to utilize correct utensils when eating. · Formal Programming for Client 3 in regard to feeding himself. 				

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	<p>updated on 5/14. The dining plan indicated client #4 was on a pureed diet with thin liquids. The dining plan included the following instructions: "If he refuses to feed himself, assist him with eating hand over hand as a training technique."</p> <p>Interview with administrative staff #2 on 9/10/14 at 10:00 AM indicated the staff should not be feeding the client #4 unless they were using a hand over hand technique.</p> <p>9-3-4(a)</p>		<p>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Program Director will review dietary assessments of all clients to ensure recommendations have been implemented.</p> <p>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · Staff training regarding Client 1, 2 and 3's dining plans and dining programming. · Home Manager will conduct a random meal observation weekly. · Home Manager will scan meal observation documentation to Program Director and Area Director upon completion of observation. <p>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · Area Director, Program Director and Nurse will review dietary assessments quarterly and monitor to ensure that dining plans are updated as necessary. · Program Director and Area Director will review meal observations weekly. <p>Addendum2 W249 Program Implementation</p>		

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			<p>The facility failed to follow the dining plans for Clients 1, 2 and 3.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · Dining Plan for Client 1 updated in regard to receiving Ensure 2x daily and in regard to Client choice of when to eat. · Formal Programming for Client 2 to utilize correct utensils when eating. · Formal Programming for Client 3 in regard to feeding himself. · Direct Support Staff will document programming daily. · Program Director will monitor that programming is documented daily. <p>1. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>Program Director will review dietary assessments of all clients to ensure recommendations have been implemented.</p> <p>1. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · Staff training regarding Client 1, 2 and 3's dining plans and dining programming. · Home Manager will conduct a daily meal observation. 	

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W000289	<p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart.</p> <p>Based on observation, record review and interview for 1 of 4 sampled clients (client #4), the facility failed to ensure the staff had interventions to manage inappropriate behavior.</p> <p>Findings include:</p> <p>During the observation on 9/8/14 from 3:25 PM to 7:00 PM, client #4 refused to get off the van at 3:45 PM. Staff #5 lifted client #4 by his gait belt down the</p>	W000289	<ul style="list-style-type: none"> · Home Manager will scan meal observation documentation to Program Director and Area Director daily upon completion of observation. 1.How will the corrective action be monitored to ensure the deficient practice will not recur? · Area Director, Program Director and Nurse will review dietary assessments quarterly and monitor to ensure that dining plans are updated as necessary. · Program Director and Area Director will review meal observations daily. <p>1.What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · Behavior plan for Client 4 revised to include interventions for "dropping to ground." <p>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · Program Director will review behavior documentation of all clients 	10/15/2014	

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	<p>steps of the van. When staff #5 and client #4 got outside the van, client #4 dropped to the ground. Staff #5 assisted client #4 to the ground by holding him under the arms. Client #4 refused to stand up and staff #5 and staff #4 tried to left him up by pulling on his arms and the gait belt. After 4 attempts to get client #4 to stand on his feet, staff #4 brought a wheel chair outside and staff #5 and #4 lifted client #4 into the chair.</p> <p>The record review for client #4 was conducted on 9/9/14 at 12:01 PM. The BSP (Behavior Support Plan) dated 5/16/14 indicated client #4 had the behaviors of SIB (Self Injurious Behavior) defined as slapping/hitting self and Anxiety defined as restlessness and pacing. The BSP did not address the behavior of dropping to the ground.</p> <p>Interview with administrative staff #2, on 9/9/14 at 10:00 AM indicated the BSP did not address client #4's refusal to walk and dropping to the ground when he was asked to do something he did not want to do. Administrative staff #2 indicated staff had a wheelchair to use PRN (as needed).</p> <p>9-3-5 (a)</p>		<p>to ensure behavior plans are addressing inappropriate behavior.</p> <p>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · Program Director will review behavior documentation quarterly to ensure that any new behaviors are addressed in behavior plan. <p>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · Area Director will review recommendations from Program Director regarding new behaviors to ensure that behavior plans are updated as needed. 				

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W000436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review and interview for 2 of 4 sampled clients (clients #2 and #4), the facility failed to ensure client #2 had a hearing aid and client #4 had a helmet that fit.</p> <p>Findings include:</p> <p>1. During the observation period on 9/8/14 from 3:25 PM to 7:00 PM, client #2 returned from her day program at 3:45 PM. Client #2 was prompted to go to the medication room at 4:10 PM by staff #4 in a loud voice. Client #2 did not respond and staff #4 prompted client #2 again in a louder voice to go to medication room.</p> <p>During the observation period on 9/9/14 from 5:30 AM to 8:00 AM. Client #2 was in the medication room getting a breathing treatment at 5:30 AM. At 5:50 AM client #2 went into the living room and started watching TV (television). The sound was turned very low on the</p>	W000436	<p>1.What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · Client 2 has had formal training in regard to hearing aids and has lost or damaged many pairs of hearing aids. IDT will consult with guardian regarding the tolerance of Client 2 wearing the hearing aids and determine if more should be purchased. · A helmet will be purchased for Client 4. <p>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All adaptive equipment for clients will be assessed by Program Director and Home Manager to ensure that all are available and in good working order. <p>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p>	10/15/2014

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	<p>TV and difficult to hear. When client #2 was asked a question, she answered with a "What?" The surveyor asked client #2 if she could hear the TV; and she again answered "what?" The question was asked in a louder tone and client #2 replied "No."</p> <p>Interview with Staff #4 on 9/8/14 at 4:10 PM indicated client #2 had dropped her hearing aid and it had,"shattered." Staff #4 indicated the insurance would not buy her another hearing aid and it had not been replaced. Staff #4 indicated it had been 2 or 3 months since her hearing aid broke.</p> <p>The record review for client #2 was conducted on 9/9/14 at 10:41 AM. A hearing evaluation was conducted on 4/10/14 and the recommendation was to continue with current amplification.</p> <p>During the observation period on 9/8/14 from 3:25 PM to 7:00 PM, client #4 was observed wearing a helmet with a bill and a face guard. The helmet would slide forward over client #4's eyes. Staff would push the helmet back if they were close and client #4 pushed on the face guard to get the helmet off his eyes. At 4:20 PM, client #4 was lying across the arms of a chair in the living room and hit the face guard 4 times which caused the</p>		<ul style="list-style-type: none"> · Staff training regarding communication of missing or damaged adaptive equipment. <p>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · Program Director will monitor adaptive equipment during monthly in-home visits. 				

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W009999	<p>helmet to slide back off his eyes. Between 5:50 PM and 6:10 PM client #4 was walking between kitchen, dining room and down hallway. Every time he got close to a staff, they would push the helmet back off of his eyes.</p> <p>Interview with staff #4, on 9/9/14 at 6:00 AM indicated client #4 had torn the lining out of the helmet with the bill and the face guard and it had not been replaced. Staff #4 indicated he had another helmet but it had a piece on the front that caused his arm to get injured and they didn't use it.</p> <p>9-3-7(a)</p> <p>State Findings</p> <p>The following community Residential Facilities for Persons with Developmental Disabilities Rule was not met.</p> <p>460 IAC 9-3-1 Governing Body</p> <p>(b) The residential provider shall report the following circumstances to the division by telephone no later than the</p>	W009999	<p>1.What corrective action will be accomplished?</p> <ul style="list-style-type: none"> State report completed for Client 4 regarding the outpatient procedure that resulted from client self-injury. <p>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> All injuries/surgeries reviewed to ensure that reportable 	10/15/2014

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	<p>first business day followed by written summaries as requested by the division.</p> <p>(6) Incidents of serious injury to a resident which require the attention of a physician beyond the initial medical evaluation or treatment and release.</p> <p>The state rule was not met as evidenced by:</p> <p>Based on record review and interview for 1 of 4 sampled clients (client #4), the facility failed to report an injury that required out patient surgery.</p> <p>Findings include:</p> <p>The record review for client #4 was conducted on 9/9/14 at 12:01 PM. The medical record dated 3/10/14 indicated client #1 was scheduled for outpatient surgery on 3/19/14 for "Cauliflower Ear." The record indicated there was an incision and drainage of left auricular (ear) hematoma.</p> <p>Interview with administrative staff #2 on 9/10/14 at 10:00 AM indicated the client injured his ear from hitting his ear with his fist. Administrative staff #2 indicated they did not report this because it was a scheduled procedure and he did not have to stay in the hospital overnight. Administrative staff #2 indicated they</p>		<p>incidents have been reported to the state.</p> <p>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · Training with Program Director regarding reportable events. <p>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · Area Director will monitor incident reports to ensure that all reportable incidents are reported. 				

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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	
	were not aware it was necessary to report a scheduled procedure. 9-3-1(b)(6)				