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
	15G488		10/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM OCCAZIO LLC	38 RYAN DR TRAFALGAR, IN 46181

(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 an extended annual recertification and state licensure survey. Dates of Survey: 10/13/15, 10/14/15 and 10/15/15. Facility Number: 001002 Provider Number: 15G488 AIMS Number: 100245020 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review completed by #09182 on 10/26/2015.	W 0000		
W 0125 Bldg. 00	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on record review and interview for 3 of 4 sampled clients (#1, #3 and #4), the facility failed to ensure clients #1, #3 and #4 exercised their rights to be gainfully employed.	W 0125	**1.What corrective action will be accomplished?** · Area Director met with Shares on 10/3/15 to discuss sheltered work opportunity for Clients 1, 3 and 4. · IDT to meet with Clients 1, 3	11/14/2015

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

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

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NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 38 RYAN DR TRAFALGAR, IN 46181	

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	Findings include: AD (Area Director) #1 was interviewed on 10/14/15 at 12:20 PM. AD #1 indicated the agency had started their own day services a year and a half ago when the agency's ownership was transitioned to a new company. AD #1 indicated when the agency opened its own day services the previous sheltered workshop in the local area closed. AD #1 indicated clients #1, #3 and #4 who had previously attended the sheltered workshop now attended the agency day services. AD #1 indicated the agency owned/operated day services offered non-paid work services and programming. AD #1 indicated the agency had attempted to coordinate paid employment opportunities with vocational rehabilitation services, however, had not been successful in obtaining work opportunities for clients #1, #3 or #4. AD #1 indicated clients #1, #3 and #4 should be offered paid work opportunities in consideration of their vocational assessments and personal preferences. 1. Client #1's record was reviewed on 10/14/15 at 9:00 AM. Client #1's Day Program Safeguard (DPS) form dated 4/7/15 indicated, "[Client #1] is not very		and 4 to discuss work options available as well as client goals in regard to work. **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?** · IDT will meet with all clients to assess and discuss work options available as well as client goals in regard to work. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · IDT will discuss goals and work options available at annual meeting for all clients. · Program Coordinator will perform a random monthly observation in the day program setting to ensure clients are engaged in meaningful activities and to evaluate if clients are interested in exploring other options in terms of day-time activity. · Bi-annually, all clients at the day program will be interviewed in regard to services provided at day program and satisfaction with the program. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?**	

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	interested in attending the (Mentor) Day Service Program. She is interested in the possibility of getting a job in the community." Client #1's FVA (Functional Vocational Assessment) form dated 7/28/15 indicated client #1 scored 4 out 5 on a scale of independence regarding initiative work skills, 5 out of 5 on a scale of independence regarding attention to task and completion, adapting change, reinforcement needs and social skills as they relate to work. Client #1's FVA dated 7/28/15 indicated client #1 scored 4 out of 5 on a scale of independence regarding her lifting strength, endurance, physical mobility, handling criticism, acting and speaking appropriately and time awareness. The review indicated client #1 could be successful at a sheltered workshop with supports. Client #1's ISP (Individual Support Plan) dated 4/7/15 indicated client #1 was emancipated and did not have a legal guardian. Client #1 decline to be interviewed. 2. Client #3's record was reviewed on 10/14/15 at 11:00 AM. Client #3's DPS form dated 10/13/15 indicated client #3 was able to stay on task, complete work and could be successful in a sheltered workshop setting.		· Program Director (QIDP) and Area Director will review all observations monthly to ensure every client has the opportunity to explore available options in terms of employment, day programming and volunteer opportunities. · Program Director (QIDP) and Area Director will review all interviews regarding client satisfaction with programs they are enrolled in to ensure that needs are met and goals are explored. · Quality Improvement Coordinator will also review all interviews regarding client satisfaction with programs they are enrolled in. **1.What is the date by which the systemic changes will be completed?** November 14, 2015	

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	Client #3's FVA form dated 7/28/15 indicated client #3's strengths included attention to task and completion, limited reinforcement needs, endurance and physical mobility. Client #3's FVA form indicated client #3 required assistance and supports regarding her social behavior that could prevent her from being successful in a community based job but could be successful in a sheltered workshop setting. The review indicated client #3 could be successful at a sheltered workshop with supports. 3. Client #4's record was reviewed on 10/14/15 at 11:30 AM. Client #4's DPS form dated 9/15/15 indicated, "[Client #4] likes to earn paychecks. He earned small paychecks at his old workshop, [client #4's] guardian would like him to be evaluated for vocational rehabilitation. However, due to [client #4's] non-compliance issues, a community job may not be a good fit for him." Client #4's FVA form dated 7/28/15 indicated client #4's vocational strengths included work initiative, moderate reinforcement needs and behavior. The review indicated client #4 could be successful at a sheltered workshop with supports. Client #4's ISP dated 1/9/15 indicated client #4 had a legal guardian. Client #4's legal guardian was			

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	interviewed on 10/15/15 at 10:34 AM. Client #4's guardian stated, "[Client #4] used to earn some money. I don't think it was much but he always seemed to enjoy earning a check. We went out together a few times and went shopping to do his spend downs. He always seemed to be happy and enjoyed it. I think he would like to be able to do some kind of work." PC (Program Coordinator) #1 was interviewed on 10/14/15 at 7:10 AM. PC #1 indicated clients #1, #3 and #4 were capable of sheltered workshop tasks. PC #1 indicated clients #1, #3 and #4 currently attended the agency owned/operated day program which did not offer paid work opportunities. 9-3-2(a)			
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 record review and interview for 1 of 4 sampled clients (#2), the facility failed to implement its policy and procedures to prevent a fall with injury and choking incident requiring emergency medical treatment regarding client #2 and the facility failed to	W 0149	**1.What corrective action will be accomplished?** · Fall Risk Plan and Choking Risk Plan for Client 2 updated to include line of sight supervision at all times except sleeping hours. · Fall Risk Plan and Choking Risk Plan for Client 2 updated to include bell on bedroom door to alert	11/14/2015

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	complete thorough investigations regarding the afore mentioned fall and choking incidents for client #2. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 10/13/15 at 2:30 PM. The review indicated the following: 1. BDDS report dated 8/25/15 indicated, "[DSP (Direct Support Staff) #1] was assisting [client #2] with dressing after his shower. The bathroom floor was slippery due to his shower. [Client #2] stood up and he fell to the ground on his right side. [DSP #1] assisted him with standing up and noticed a cut above his right eye that was bleeding. [DSP #1] applied pressure and stopped the bleeding. The supervisor was notified. The supervisor advised that [client #2] be taken to the ER (Emergency Room). [Client #2] was taken to [hospital] ER. [Client #2] got 4 stitches above his right eye." The 8/25/15 BDDS report indicated, "Staff will be advised to make sure (the) floor is dried before [client #2] gets out of (the) shower."		staff if Client 2 gets up during the night. · Choking Risk Plan updated to include locking of food items not on Client 2's diet and non-edible items that Client 2 has attempted to eat. · Human Rights Approval obtained for all restrictions. · Formal training with Client 2 on the difference between edible and nonedible items. · Review of initial investigations and addendum to include assessment of effectiveness of preventative measures. · Review of initial investigations and addendum to include measures put in place to prevent injuries from falls and choking incident. **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 (QIDP) will review all risk plans to ensure preventative measures are in place to prevent injury for clients. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Staff training regarding revisions to Client 2's updated Fall Risk Plan and Choking Risk Plan. · Staff training regarding	

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	Summary of Internal Investigation Report (SIIR) dated 8/27/15 indicated the following narrative interview with DSP #1 who was assisting client #2 with showering when he fell and sustained the laceration on his forehead: -"He stood up- I was helping him pull on his pants, and he slipped on the wet floor." The 8/27/15 SIIR indicated, "Evidence support staff was providing appropriate supervision at the time of the fall." 2. BDDS report dated 9/1/15 indicated, "[Client #2] had been drooling excessively and vomiting. [Client #2] also appeared to be excessively sleepy. [Client #2] is non-verbal. This seemed to be unusual behavior for him. [Nurse #1] advised that he be evaluated at the ER. [Client #2] was taken to [hospital] ER. A chest x-ray was done and a mass was discovered in his esophagus. [Client #2] was admitted to [hospital] and kept overnight. A scope was performed today. The mass was discovered to be a piece of smoked sausage. The smoked sausage was removed. [Client #2] is on a pureed diet. It is unclear how he was able to obtain the non-pureed piece of smoked sausage."		formal programming in place for Client 2. · Formal training with Program Director (QIDP) regarding thorough investigations. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · Program Coordinator will do a weekly observation of Client 2 to assess effectiveness of current revisions to Client 2's Risk Plans. · Documentation of the PC observation will be forwarded to Nurse and Program Director (QIDP) immediately following the observation. · Program Coordinator will communicate concerns with effectiveness of revisions to Risk Plans immediately to Nurse and Program Director (QIDP) so that further revisions can be made if necessary. · Area Director will review all investigations to ensure that they are thorough. **1.What is the date by which the systemic changes will be completed?** November 14, 2015	

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	-SIIR dated 9/4/15 indicated, "Evidence supports that [client #2] ate a whole piece of smoked sausage several days prior to the ER visit. Evidence supports that [client #2] was able to get a hold of the smoked sausage without staff knowing." Client #2's record was reviewed on 10/14/15 at 10:00 AM. Client #2's Fall Risk Plan dated 3/4/15 indicated, "(1.) Staff should monitor environmental concerns at home (wet floor, anything on floor that should be picked up) and at workshop." Client #2's Choking Risk Plan dated 3/4/15 indicated, "[Client #2's] diet order-Pureed Diet/Thin Liquids. [Client #2] should be monitored at all times when he is eating." Client #2's 3/4/15 Choking Risk Plan indicated, "Staff should monitor to ensure that [client #2] is not taking other's food. Choking, [client #2] is (a) High risk for choking." The review indicated the facility failed to implement client #2's Fall Risk Plan dated 3/4/15 to prevent client #2 from falling after a shower and requiring emergency medical treatment as a result. The 8/27/15 SIIR did not indicate documentation of a finding of substantiated neglect regarding facility staff's failure to implement client #2's			

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	3/4/15 Fall Risk Plan which indicated staff should ensure the bathroom floor was not wet/slippery. The review indicated the facility failed to implement client #2's Choking Risk Plan dated 3/4/15 to prevent client #2 from choking on a piece of smoked sausage and requiring emergency medical services as a result. The 9/4/15 SIIR did not indicate documentation of finding fact and determination as to whether or not client #2's rights were violated by staff's failure to implement his 3/4/15 Choking Risk Plan. AD (Area Director) #1 was interviewed on 10/14/15 at 12:20 PM. AD #1 indicated the facility's abuse and neglect policy should be implemented. AD #1 indicated client #2's Fall and Choking Risk Plans should be implemented to prevent falls and choking. AD #1 indicated the investigation of allegations of abuse, neglect and mistreatment should be thorough. The facility's policy and procedures were reviewed on 10/15/15 at 9:32 AM. The facility's Quality and Risk Management policy dated April 2011 included but was not limited to the following definitions regarding abuse, neglect and mistreatment:			

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	-"[Agency] promotes a high quality of service and seeks to protect individuals receiving [agency] 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." -"(e.) Failure to provide appropriate supervision, care or training; (f.) Failure to provide a safe, clean and sanitary environment." -"(p.) Inadequate staff support for an individual, including inadequate supervision, with the potential for: (1.) Significant harm or injury to an individual...." 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 record review and interview for 2 of 2 allegations of abuse and neglect reviewed, the facility failed to complete thorough investigations regarding a fall with injury and a choking incident	W 0154	**1.What corrective action will be accomplished?** · Review of initial investigations and addendum to include assessment of effectiveness of preventative measures. · Review of initial	11/14/2015

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	requiring emergency medical treatment regarding client #2. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 10/13/15 at 2:30 PM. The review indicated the following: 1. BDDS report dated 8/25/15 indicated, "[DSP (Direct Support Staff) #1] was assisting [client #2] with dressing after his shower. The bathroom floor was slippery due to his shower. [Client #2] stood up and he fell to the ground on his right side. [DSP #1] assisted him with standing up and noticed a cut above his right eye that was bleeding. [DSP #1] applied pressure and stopped the bleeding. The supervisor was notified. The supervisor advised that [client #2] be taken to the ER (Emergency Room). [Client #2] was taken to [hospital] ER. [Client #2] got 4 stitches above his right eye." The 8/25/15 BDDS report indicated, "Staff will be advised to make sure (the) floor is dried before [client #2] gets out of (the) shower." Summary of Internal Investigation Report		investigations and addendum to include measures put in place to prevent injuries from falls and choking incident. **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?** · All clients have the potential to be affected by the same deficient practice. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Formal training with Program Director (QIDP) regarding thorough investigations. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · Area Director will review all investigations to ensure that they are thorough. **1.What is the date by which the systemic changes will be completed?** November 14, 2015	

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	(SIIR) dated 8/27/15 indicated the following narrative interview with DSP #1 who was assisting client #2 with showering when he fell and sustained the laceration on his forehead: -"He stood up- I was helping him pull on his pants, and he slipped on the wet floor." The 8/27/15 SIIR indicated, "Evidence support staff was providing appropriate supervision at the time of the fall." 2. BDDS report dated 9/1/15 indicated, "[Client #2] had been drooling excessively and vomiting. [Client #2] also appeared to be excessively sleepy. [Client #2] is non-verbal. This seemed to be unusual behavior for him. [Nurse #1] advised that he be evaluated at the ER. [Client #2] was taken to [hospital] ER. A chest x-ray was done and a mass was discovered in his esophagus. [Client #2] was admitted to [hospital] and kept overnight. A scope was performed today. The mass was discovered to be a piece of smoked sausage. The smoked sausage was removed. [Client #2] is on a pureed diet. It is unclear how he was able to obtain the non-pureed piece of smoked sausage." -SIIR dated 9/4/15 indicated, "Evidence			

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	supports that [client #2] ate a whole piece of smoked sausage several days prior to the ER visit. Evidence supports that [client #2] was able to get a hold of the smoked sausage without staff knowing." Client #2's record was reviewed on 10/14/15 at 10:00 AM. Client #2's Fall Risk Plan dated 3/4/15 indicated, "(1.) Staff should monitor environmental concerns at home (wet floor, anything on floor that should be picked up) and at workshop." Client #2's Choking Risk Plan dated 3/4/15 indicated, "[Client #2's] diet order- Pureed Diet/Thin Liquids. [Client #2] should be monitored at all times when he is eating." Client #2's 3/4/15 Choking Risk Plan indicated, "Staff should monitor to ensure that [client #2] is not taking other's food. Choking, [client #2] is (a) High risk for choking." The review indicated the facility failed to implement client #2's Fall Risk Plan dated 3/4/15 to prevent client #2 from falling after a shower and requiring emergency medical treatment as a result. The 8/27/15 SIIR did not indicate documentation of a finding of substantiated neglect regarding facility staff's failure to implement client #2's 3/4/15 Fall Risk Plan which indicated			

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	staff should ensure the bathroom floor was not wet/slippery. The review indicated the facility failed to implement client #2's Choking Risk Plan dated 3/4/15 to prevent client #2 from choking on a piece of smoked sausage and requiring emergency medical services as a result. The 9/4/15 SIIR did not indicate documentation of finding fact and determination as to whether or not client #2's rights were violated by staff's failure to implement his 3/4/15 Choking Risk Plan. AD (Area Director) #1 was interviewed on 10/14/15 at 12:20 PM. AD #1 indicated the investigation of allegations of abuse, neglect and mistreatment should be thorough. 9-3-2(a)			
W 0209 Bldg. 00	483.440(c)(2) INDIVIDUAL PROGRAM PLAN Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate. Based on record review and interview for 2 of 4 sampled clients (#2 and #3), the facility failed to ensure clients #2 and #3's guardians participated in the development of their ISPs (Individual	W 0209	**1.What corrective action will be accomplished?** · Client 2 and 3 guardians contacted regarding outcomes of ISPs and forwarded proper paperwork.	11/14/2015

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	15G488		10/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM OCCAZIO LLC	38 RYAN DR TRAFALGAR, IN 46181

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	Support Plans). Findings include: 1. Client #2's record was reviewed on 10/14/15 at 10:00 AM. Client #2's ISP dated 5/20/15 indicated client #2 had a legal guardian. Client #2's record did not indicate documentation of client #2's guardian's participation in the development of client #2's ISP dated 5/20/15. 2. Client #3's record was reviewed on 10/14/15 at 11:00 AM. Client #3's ISP dated 9/4/15 indicated client #3 had a legal guardian. Client #4's record did not indicate documentation of client #3's guardian's participation in the development of client #3's ISP dated 9/4/15. QIDP (Qualified Intellectual Disability Professional) #1 was interviewed on 10/14/15 at 11:20 AM. QIDP #1 indicated there was not additional documentation available for review regarding clients #2 or #3's guardian's participation in their ISPs. 9-3-4(a)		· Signature obtained from Client 2 and 3 guardians for approval of ISP outcomes. **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?** · All client ISPs will be reviewed to ensure participation of guardian. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Program Director (QIDP) will contact guardians prior to annual ISP meetings to ensure that they are aware of meeting date and time. · Program Director (QIDP) will make all necessary concessions if guardian is unable to attend meeting (change of date or time; or telephone involvement). · If guardian is unable to attend in person or by phone, Program Director (QIDP) will contact guardian regarding the outcomes for approval and modifications. · Program Director (QIDP) will forward all paperwork via certified letter immediately following the ISP for review, approval and signature of approval. **1.How will the corrective action be monitored to ensure the**	

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			deficient practice will not recur? · Area Director will review documentation bi-weekly to ensure all ISPs are up to date and completed in a timely manner. **1.What is the date by which the systemic changes will be completed?** November 14, 2015	
W 0263 Bldg. 00	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. Based on record review and interview for 2 of 4 sampled clients #2 and #3, the facility failed to ensure clients #2 and #3's behavior management program/psychotropic medications were conducted with the written informed consent of clients #2 and #3's legal guardians. Findings include: 1. Client #2's record was reviewed on 10/14/15 at 10:00 AM. Client #2's Active Medication/Physician's Orders form dated 10/1/15 indicated client #2 received Invega ER (Extended Release) 6 milligram tablet (anxiety), Trazodone	W 0263	**1.What corrective action will be accomplished?** · Client 2 and 3 guardians contacted regarding approval of behavior management/psychotropic medications for approval. · Signature obtained from Client 2 and 3 guardians for approval of behavior management plan program/psychotropic medications. **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?** · All injuries/surgeries reviewed to ensure that reportable incidents have been reported to the state.	11/14/2015

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	100 milligram tablet (sleep management), Guanfacine 1 milligram tablet (autism/ADHD (attention deficit/hyperactivity disorder)) and Olanzapine 15 milligrams (anxiety/autism). Client #2's ISP (Individual Support Plan) dated 5/20/15 indicated client #2 had a legal guardian. Client #2's record did not indicate documentation of client #2's legal guardian's written informed consent for the use of Invega, Trazodone, Guanfacine or Olanzapine for the management of client #2's behavior. 2. Client #3's record was reviewed on 10/14/15 at 11:00 AM. Client #3's Active Medication/Physician's Orders form dated 10/1/15 indicated client #3 received Risperidone 0.5 milligram tablet (anxiety) and Sertraline 100 milligram tablet (depression/anxiety). Client #3's ISP dated 9/4/15 indicated client #3 had a legal guardian. Client #3's record did not indicate documentation of client #3's legal guardian's written informed consent for the use of Risperidone or Sertraline for the management of client #3's behavior. QIDP (Qualified Intellectual Disability Professional) #1 was interviewed on 10/14/15 at 11:20 AM. QIDP #1 indicated there was not additional		· All client behavior management programs/psychotropic medications will be reviewed to ensure participation of guardian. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Program Director (QIDP) will contact guardians prior to annual ISP meetings to ensure that they are aware of meeting date and time. · Program Director (QIDP) will make all necessary concessions if guardian is unable to attend meeting (change of date or time; or telephone involvement). · If guardian is unable to attend in person or by phone, Program Director (QIDP) will contact guardian regarding the outcomes for approval and modifications. · Program Director (QIDP) will forward all paperwork via certified letter immediately following the ISP for review, approval and signature of approval. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · Area Director will review documentation bi-weekly to ensure all ISPs are up to date and completed in a timely manner (including approval of behavior management program/psychotropic medications).	

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	documentation available for review regarding clients #2 or #3's guardian's written informed consent regarding the use of clients #2 or #3's psychotropic medications for behavior management. 9-3-4(a)		**1.What is the date by which the systemic changes will be completed?** November 14, 2015	
W 0312 Bldg. 00	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for 1 of 3 sampled clients who received psychotropic medications (#2), the facility failed to ensure client #2's medications used for behavior management were included in an active treatment program to reduce or eliminate the need for the medication. Findings include: Client #2's record was reviewed on 10/14/15 at 10:00 AM. Client #2's Active Medication/Physician's Orders form dated 10/1/15 indicated client #2 received Invega ER (Extended Release) 6 milligram tablet (anxiety), Trazodone 100 milligram tablet (sleep management), Guanfacine 1 milligram tablet	W 0312	**1.What corrective action will be accomplished?** · Client 2's behavior plan has been updated to include all psychotropic medications **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?** · All client behavior plans and medications will be reviewed to ensure that all psychotropic medications are included in behavior plan. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**	11/14/2015

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	(autism/ADHD (attention deficit/hyperactivity disorder)) and Olanzapine 15 milligrams (anxiety/autism). Client #2's BSP (Behavior Support Plan) dated 10/21/14 indicated client #2 had an active treatment program for Olanzapine and Invega but did not include documentation of an active treatment program for Guanfacine or Trazodone to reduce or eliminate the need for the medications. QIDP (Qualified Intellectual Disability Professional) #1 was interviewed on 10/14/15 at 11:20 AM. QIDP #1 indicated client #2's BSP dated 10/21/14 did not include an active treatment program to reduce or eliminate client #2's use of Trazodone or Guanfacine. 9-3-5(a)		· IDT will meet following all psychotropic medication changes to discuss change and to ensure changes are made to behavior plan to reflect changes. · Behavior Plan will be changed to reflect changes and forwarded to all team members within 24 hours of change. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · All behavior plans will be reviewed annually for accuracy in terms of psychotropic medications. · All behavior plans will be reviewed immediately following a change in medication by all members of team. **1.What is the date by which the systemic changes will be completed?** November 14, 2015	
W 0323 Bldg. 00	483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview for 1 of 4 sampled clients (#4), the facility's nursing services failed to ensure client #4 received an annual physical examination.	W 0323	**1.What corrective action will be accomplished?** · Client 4 had annual physical on 10/30/2015. **1.How will we identify other**	11/14/2015

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	Findings include: Client #4's record was reviewed on 10/14/15 at 11:30 AM. Client #4's annual physical assessment was dated 8/21/14. Client #4's record did not indicate additional documentation of an annual physical evaluation since 8/21/14. Program Coordinator (#1) was interviewed on 10/14/15 at 11:20 AM. PC #1 indicated client #4 had an appointment for his annual physical but had missed the appointment. PC #1 indicated client #4's annual was rescheduled but had not yet occurred. PC #1 indicated client #4's had not had an annual physical completed since 8/21/14. 9-3-6(a)		**residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All client appointments will be reviewed to ensure that clients have had annual physicals with physician. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Program Coordinator provided with appointment tracking sheet to ensure that all appointments are done in a timely manner. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · Appointment tracking form will be reviewed by nurse or Program Director (QIDP) weekly to ensure that all appointments are up to date. **1.What is the date by which the systemic changes will be completed?** November 14, 2015	
W 0336 Bldg. 00	483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical			

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	care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. Based on record review and interview for 1 of 4 sampled clients (#3), the facility's nursing services failed to ensure client #3's health status was reviewed on a quarterly basis. Findings include: Client #3's record was reviewed on 10/14/15 at 11:00 AM. Client #3's record indicated client #3 had a quarterly physical review on 1/30/15 and annual physical review on 8/11/15. The review did not indicate documentation of quarterly physical review between 1/30/15 and 8/11/15. QIDP (Qualified Intellectual Disability Professional) #1 was interviewed on 10/14/15 at 11:20 AM. QIDP #1 indicated physical assessments should be completed each quarter by the nurse or physician. QIDP #1 indicated there was not additional documentation of quarterly health reviews available for client #2. 9-3-6(a)	W 0336	**1.What corrective action will be accomplished?** · Client 3 had a quarterly physical on 11/6/1015. **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?** · All client appointments will be reviewed to ensure that clients have had quarterly physicals. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Program Coordinator provided with appointment tracking sheet to ensure that all appointments are done in a timely manner. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · Appointment tracking form will be reviewed by nurse or Program Director (QIDP) weekly to ensure that all appointments are up to date. **1.What is the date by which the systemic changes will be**	11/14/2015

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			completed? November 14, 2015	
W 9999 Bldg. 00	1. State Findings The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met. 460 IAC 9-3-1 Governing Body (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by division: (11.) An emergency intervention for the individual resulting from: (a.) a physical symptom; (b.) a medical or psychiatric condition; (c.) any other event. (15.) A fall resulting in injury, regardless of the severity of the injury. (16.) A medication error or medical treatment error as follows: (a) wrong medication given; (b) wrong medications dosage given; (c) missed medication-not given; (d) medication given wrong route; or (e) medication error that jeopardized an individual's health and welfare and requires medical attention.	W 9999	**1.What corrective action will be accomplished?** · Program Director (QIDP) trained on reporting guidelines and timeliness of reporting incidents to state agencies. **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?** · All clients have the potential to be affected by the same deficient practice. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Program Coordinator (QIDP) will inform Area Director of all reportable incidents immediately. · Program Coordinator (QIDP) will forward all reports to Area Director within 24 hours of incident. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?**	11/14/2015

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	This state rule was not met as evidenced by: Based on record review and interview for 4 of 6 medication administration errors, ER (Emergency Room) visits and falls with injuries reviewed, the facility failed to ensure two incidents of medication administration errors regarding clients #1 and #2, a fall with injury for client #4 and an ER visit for client #5 were reported to BDDS (Bureau of Developmental Disabilities Services) within 24 hours of knowledge of the incidents. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 10/13/15 at 2:30 PM. The review indicated the following: 1. BDDS report dated 7/8/15 indicated on 7/6/15 client #5 was taken to the ER (Emergency Room) to be evaluated for an injured shoulder. 2. BDDS report dated 5/22/15 indicated on 5/20/15 client #4 had fallen and sustained 2 scrapes on his left pinky finger. 3. BDDS report dated 10/3/15 indicated		· Area Director will record all reportable incidents on a tracking form to ensure that incidents are reported within 24 hours. **1.What is the date by which the systemic changes will be completed?** November 14, 2015	

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	the facility had knowledge on 9/29/15 of a 9/28/15 medication administration error regarding client #1's medication. 4. BDDS report dated 10/3/15 indicated the facility had knowledge on 9/29/15 of a 9/28/15 medication administration error regarding client #2's medication. AD (Area Director) #1 was interviewed on 10/14/15 at 12:20 PM. AD #1 indicated BDDS reportable incidents such as ER visits, falls with injury and medication administration errors should be reported to BDDS within 24 hours of the facility's knowledge of the incident. 9-3-1(b)			