STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM OCCAZIO LLC	10311 E JACKSON SELMA, IN 47383

(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
W000000	This visit was for a post certification revisit to the predetermined full annual recertification and state licensure survey completed on 05/09/14. Dates of Survey: June 11, 12, 13 and 20, 2014. Facility Number: 000878 Provider Number: 15G364 AIMS Number: 100249230 Surveyor: Vickie Kolb, RN These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/26/14 by Ruth Shackelford, QIDP.	W000000		
W000104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) and 3 additional clients (#5, #6 and #7), the governing body failed to exercise general policy and operating direction over the facility to	W000104	The home will be maintained and kept in good repair. New carpet will be installed in the living room. Carpet will be removed in the bedroom and replaced with tile. New furniture, a couch and love seat, have been ordered for the home. Outlet covers will be	07/20/2014

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/20/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383	

(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
	ensure: __The home was maintained and in good repair. __Sufficient numbers of direct care staff were working to supervise and care for clients #1, #2, #3, #4, #5, #6 and #7 throughout the day to meet their needs. __All injuries of unknown origin were thoroughly investigated for clients #4 and #6. __The PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) integrated coordinated and monitored client #1's, #2's, #3's #4, #5's, #6's and #7's care. Findings include: 1. Observations were conducted at the group home of clients #1, #2, #3, #4, #5, #6 and #7 on 6/11/14 between 4 PM and 7:30 PM. __The linoleum and wood floors throughout the home were in need of being swept and mopped. There were crevices of dirt, dust and dried particles around all the baseboards throughout the home, in the hallways, bathrooms, clients' bedrooms and the laundry/medication room. __The laundry/medication room had a dried brown substance that was dripped and splattered over one half of the laundry/medication room door.		inspected throughout the home and replaced as necessary when missing, broken or cracked. The home manager will perform daily environmental checks and report maintenance repairs/issues to the maintenance department and the PD(QIDP) by completing a maintenance request. Staff will be trained by the home manager and/or the PD(QIDP) on the daily checklists that include daily and deep cleaning tasks. The home manager will review the checklists for accuracy. The home manager will perform re-trainings on these tasks as needed. The PD(QIDP) will do weekly environmental checks of the home to ensure maintenance requests are completed and that the house is clean and in good condition. Will be completed by 7-20-14. All injuries of unknown origin will be fully investigated per company policy. The PD(QIDP) will attend investigation training in August. Until that time, investigations will be performed by a trained PD(QIDP), the Area Director or Quality Assurance. Investigations will be reviewed and monitored by the Area Director and/or quality assurance to ensure complete, thorough investigations are completed within five business days. Will be completed by 7-20-14 The PD(QIDP) will be trained by the Area Director to integrate,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/20/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383	

(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
	__The paint was chipped and missing throughout the hallways and the wood around all the door frames was chipped and splintered. __The curtains in all of the clients' bedrooms were hanging crooked and/or falling down from the curtain rods. __The small bathroom near the dining room had an unidentifiable dried substance that had dripped down and dried on the wall behind the trash can. __There were two worn lounge chairs, a recliner and a blue plaid love seat and matching sofa in the living room. The cushions of the lounge chairs were worn, flat and misshapen and the back of the love seat was broken down. __There were four electrical outlets in client #4's and #6's bedroom. One of the outlets was missing the cover and two of the outlets were broken. __The two step stool used in the kitchen and stored beside the small refrigerator was brown with dirt and dust. Interview with the RM (Residential Manager) on 6/11/14 at 6:30 PM stated the night shift staff were to clean the home nightly and "obviously they didn't do it." The RM stated the home was in need of a "deep cleaning." The RM stated the substance on the back of the door in the medication room was "more than likely dried pudding. I'll get that washed		coordinate and monitor client care. The PD(QIDP) will visit the clients in their home a minimum of once a week to monitor their care. The Area Director will do monthly audits to ensure client care. Will be completed by 7-20-14 Staff numbers for the evening shift have been increased. The Home Manager will manage the schedule daily and make necessary adjustments to ensure staffing is in place. The PD(QIDP) will monitor the schedule on a weekly basis to ensure staffing is in place. Will be completed by 7-20-14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/20/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383	

(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
	off." The RM stated the facility maintenance staff had been in the home "trying to get things back in order." The RM indicated most of the damage to the walls and woodwork was from the clients' wheelchairs. The RM indicated the facility had ordered new carpet and furniture for the living room. Interview with the PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) on 6/11/14 at 7 PM indicated the home was to be cleaned nightly, maintained and in good repair. The PD stated, "We'll get those outlet covers replaced immediately." 2. The governing body failed to exercise general policy and operating direction over the facility to ensure all injuries of unknown origin were thoroughly investigated for clients #4 and #6 and to ensure sufficient numbers of direct care staff were working to supervise and care for clients #1, #2, #3, #4, #5, #6 and #7 throughout the day to meet the clients' needs. Please see W149. 3. The governing body failed to exercise general policy and operating direction over the facility to ensure all injuries of unknown origin were thoroughly investigated for clients #4 and #6. Please see W154.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/20/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383	

(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
	4. The governing body failed to exercise general policy and operating direction over the facility to ensure the PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) integrated, coordinated and monitored client #1's, #2's, #3's #4, #5's, #6's and #7's care. Please see W159. 5. The governing body failed to exercise general policy and operating direction over the facility to ensure sufficient numbers of direct care staff were working to supervise and care for the clients throughout the day to meet client #1's, #2's, #3's, #4's, #5's, #6's and #7's needs. Please see W186. This deficiency was cited on 5/9/14. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-1(a)			
W000149	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 observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) and 3 additional clients	W000149	All injuries of unknown origin will be fully investigated per company policy. The PD(QIDP) will attend investigation training in August.	07/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/20/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383	

(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
	(#5, #6 and #7), the facility failed to implement written policy and procedures: __To ensure all injuries of unknown origin were thoroughly investigated for clients #4 and #6. __To ensure sufficient numbers of direct care staff were working to supervise and care for clients #1, #2, #3, #4, #5, #6 and #7 throughout the day to meet the clients' needs. Findings include: The facility's reportable and investigative records were reviewed on 6/12/14 at 11 AM. The facility's 12/12 policy and procedure entitled Quality and Risk Management 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.... __Activities initiated by Mentor that require mandated investigative components.... c. ...injuries of unknown origin...." 1. For 2 of 2 injuries of unknown origin for clients #4 and #6, the facility failed to ensure a thorough investigation was		Until that time, investigations will be performed by a trained PD(QIDP), the Area Director or Quality Assurance. Investigations will be reviewed and monitored by the Area Director and/or quality assurance to ensure complete, thorough investigations are completed within five business days. Will be completed by 7-20-14 Staff numbers for the evening shift have been increased. The Home Manager will manage the schedule daily and make necessary adjustments to ensure staffing is in place. The PD(QIDP) will monitor the schedule on a weekly basis to ensure staffing is in place. Will be completed by 7-20-14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/20/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383	

(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
	conducted. Please see W154. 2. For 4 of 4 sampled clients (#1, #2, #3 and #4) and 3 additional clients (#5, #6 and #7), the facility failed to provide sufficient direct care staff to supervise and care for the clients throughout the day to meet the clients' needs. Please see W186. This deficiency was cited on 5/9/14. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-2(a)			
W000154	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 injuries of unknown origin for clients #4 and #6, the facility failed to ensure a thorough investigation was conducted. Findings include: The facility's reportable and investigative records were reviewed on 6/12/14 at 11 AM.	W000154	All injuries of unknown origin will be fully investigated per company policy. The PD(QIDP) will attend investigation training in August. Until that time, investigations will be performed by a trained PD(QIDP), the Area Director or Quality Assurance. Investigations will be reviewed and monitored by the Area Director and/or quality assurance to ensure complete, thorough investigations are completed within five business days. Will be completed by 7-20-14	07/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/20/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383	

(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
	The 6/5/14 Investigative summary indicated on 6/5/14 the staff noticed a bruise on client #6's left calf approximately one cm (centimeter) in size. The investigative summary indicated interviews with two direct care staff and the home manager. The summary indicated client #6 was nonverbal and did not respond to questions. The investigative records indicated no interviews with client #6's housemates and/or other staff that worked in the home and/or the day program that client #6 attended. The facility records did not indicate a thorough investigation was conducted. A 5/26/14 BDDS (Bureau of Developmental Disabilities Services) report indicated on 5/25/14 at 4:55 PM "[Client #4] was resting on the couch. [Client #4] awoke and decided she wanted to get up. [Client #4] wears a gait belt that staff assist her with while ambulating. [Client #4] did not wait on staff assistance and did not make staff aware she was getting up before she got off the couch. [Client #4] tried to ambulate without staff assistance and she fell. On the way down [client #4] hit her left ear on the entertainment center. [Client #4] sustained a laceration to her left ear lobe. __The Investigative summary dated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/20/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383	

(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
	5/25/14 indicated two interviews, one interview with the RM (Residential Manager) and one interview with staff #3. The summary indicated the RM was in a bedroom changing a client and heard client #4 "yell" and staff #3 was in the bathroom with another client. The investigative record indicated neither staff in the home witnessed client #4's injury. The investigative record did not indicate the number of staff in the home and/or the clients that were in the home at the time of client #4's injury. The investigative record indicated no other staff interviews and/or client interviews. The facility records did not indicate a thorough investigation was conducted. Interview with the AD (Area Director) on 6/12/14 at 1 PM indicated all injuries of unknown origin were to be investigated thoroughly. This deficiency was cited on 5/9/14. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-2(a)			
W000159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/20/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383	

(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
	be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, interview and record review for 4 of 4 sample clients (#1, #2, #3 and #4) and 3 additional clients (#5, #6 and #7), the facility failed to ensure the PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) integrated, coordinated and monitored the clients' care. The PD failed to ensure: __Sufficient food was in the home to be able to follow the facility menus and to supply client #7's snack box as indicated in client #7's behavior plan. __The staff followed the facility menus and/or provided appropriate menu items when substituting food for all clients in the group home (clients #1, #2, #3, #4, #5, #6 and #7). __Client #2 was scheduled to have the wax removed from his ears. __Written signature was obtained from client #1's, #2's and #4's legal representatives in regard to the clients' program plans. __All injuries of unknown origin were thoroughly investigated for clients #4 and #6. __The staff documented the clients' data on the clients' record as indicated in each of the clients' ISPs (Individual Support Plans). __Client #3's wheelchair was clean and in	W000159	PD(QIDP) will train the Home Manager on the menu and grocery list and supplying client #7's snack box. PD(QIDP) will do weekly checks to ensure all ingredients are in the home per the menu and that client #7's snack box is being supplied. Will be completed by 7-20-14 Home Manager will train staff on the menus, how to follow them and review the food substitution lists. The Home Manager will review the menu substitution list on a weekly basis. The Home Manager will perform meal observations weekly to ensure the menu is being followed and substitutions are being made correctly where applicable. The PD(QIDP) will do bi-monthly meal observations to ensure the menu is being followed and that food substitutions are made correctly. Will be completed by 7-20-14 The Home Manager will schedule an appointment to have ear wax removed for client #2. The Home Manage will provide the appointment date to the PD(QIDP). The PD(QIDP) will follow-up with the Home Manager to ensure appointment takes place. Will be completed by 7-20-14 Signed signature pages for individual plans will be attached to	07/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/20/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383	

(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
	good repair and client #1 was provided a boot splint. __Sufficient numbers of direct care staff were working to supervise and care for the clients throughout the day to meet client #1's, #2's, #3's, #4's, #5's, #6's and #7's needs. Findings include: 1. Observations were conducted at the group home on 6/11/14 between 4 PM and 7:30 PM. A large plastic container was observed on the food pantry shelf in the kitchen with client #7's name on it. In the box were two large cans of cooking spray, one bag of cheese puffs, one gallon of punch, a half a gallon of vinegar, one can of soup, a small zip lock baggy of Fig cookies and one box of graham crackers and pudding snacks with client #3's initials on them. Client #7's record was reviewed on 6/12/14 at 4 PM. Client #7's 7/2/13 ISP indicated client #7 was to be "supervised at all times around food as he will eat uncontrollably and very fast. Also [client #7] tends to put very large pieces of food in his mouth...." Client #7's BSP (Behavior Support Plan) of 7/30/12 indicated when client #7 was observed "stealing food or eating out of the trash can staff should immediately say '[Client		the client's plan in Therap. In the absence of legal representatives, the signature page will be mailed to the representative via certified mail. This information will be documented in Therap. The PD(QIDP) will follow-up with the legal representative via mail email or phone when/if the signature sheet is not returned within two weeks of the return receipt date. This information will be documented in Therap. Will be completed by 7-20-14 All injuries of unknown origin will be fully investigated per company policy. The PD(QIDP) will attend investigation training in August. Until that time, investigations will be performed by a trained PD(QIDP), the Area Director or Quality Assurance. Investigations will be reviewed and monitored by the Area Director and/or quality assurance to ensure complete, thorough investigations are completed within five business days. Will be completed by 7-20-14 Home Manager will retrain the staff to document the clients' data per the ISPs. Home Manager will audit documentation twice weekly. PD(QIDP) will audit program documentation weekly. Will be completed by 7-20-14 Staff will be retrained to report deficits with clients' adaptive equipment. Will be completed by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/20/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383	

(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
	#7] you need to stop stealing, and/or eating out of the trash can (whichever applies at the time) that is not a healthy choice. If you are hungry you can go to your free foods in the cabinet. Remember, these are here for you whenever you want'." Interview with client #7 on 6/11/14 at 5:20 PM stated his snack box had not been filled "for a long time." Client #7 pulled out snacks with client #3's initials on them from the box labeled with his name and showed them to this surveyor. Client #7 stated, "That's not my stuff." Interview with the RM (Residential Manager) on 6/11/14 at 5:30 PM indicated she bought the groceries in the home and she stocked client #7's snack box. The RM stated, "I haven't filled it for a while. I just haven't had the time to do the shopping." The RM indicated she was going that evening to do the grocery shopping and would refill client #7's snack box. 2. Client #2's record was reviewed on 6/12/14 at 4 PM. Client #2's hearing evaluation of 5/21/14 indicated a recommendation for client #2 to have the wax removed from his ears "ASAP (as soon as possible) w/sedation (with sedation)." Client #2's record indicated		7-20-14 Staff will be retrained to clean client #3's wheelchair on a daily basis and document in the MAR. Home Manager will audit the MAR daily to ensure daily cleaning of the wheelchair. Will be completed by 7-20-14 Home Manager will schedule an appointment for client #1's boot splint. Home Manager will inform the PD(QIDP) of this appointment. The PD(QIDP) will follow-up with the Home Manager after the appointment. Will be completed by 7-20-14 Staff numbers for the evening shift have been increased. The Home Manager will manage the schedule daily and make necessary adjustments to ensure staffing is in place. The PD(QIDP) will monitor the schedule on a weekly basis to ensure staffing is in place. Will be completed by 7-20-14 PD(QIDP) will implement a plan for client #4's monitoring while in the shower, toileting and reclining to decrease the risk of falls. PD(QIDP) will train staff on this plan. Will be completed by 7-20-14 Home Manager will make an appointment for client #1 to have a hearing evaluation with the PCP or audiologist. Home Manager	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/20/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383	

(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
	client #2 had not had and/or was not scheduled to have the wax removed from his ears. Email interview on 6/13/14 at 3:40 PM with the AD (Area Director) indicated the home manager was responsible for making all appointments with the oversight from the PD/QIDP. The AD indicated the RM called 6/13/14 to make the appointment and would call again on Monday (6/16/14) if the RM did not get a response from the doctor's office. 3. The PD failed to ensure all injuries of unknown origin were thoroughly investigated for clients #4 and #6 and to ensure sufficient numbers of direct care staff were working to supervise and care for clients #1, #2, #3, #4, #5, #6 and #7 throughout the day to meet the clients' needs. Please see W149. 4. The PD failed to ensure all injuries of unknown origin were thoroughly investigated for clients #4 and #6. Please see W154. 5. The PD failed to ensure sufficient numbers of direct care staff were working to supervise and care for the clients throughout the day to meet client #1's, #2's, #3's, #4's, #5's, #6's and #7's needs. Please see W186.		will document the appointment and results in Therap. Will be completed by 7-20-14 Home Manager will make an appointment for client #4 to have a vision screening with the PCP or optometrist. Home Manager will document the appointment and results in Therap. Will be completed by 7-20-14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/20/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383	

(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
	6. The PD failed to provide evidence of written signature from client #1's, #2's and #4's legal representative to ensure the representatives reviewed and participated in the Interdisciplinary Team process and development of the clients' ISPs (Individual Support Plans). Please see W209. 7. The PD failed to ensure client #4's ISP addressed how the staff were to monitor and assist client #4 while showering, toileting and reclining to prevent further injury from falls. Please see W240. 8. The PD failed to ensure the staff documented the clients' program data as directed for clients #1, #2, #3 and #4. Please see W252. 9. The PD failed to ensure client #1's hearing and client #4's vision were evaluated annually. Please see W323. 10. The PD failed to ensure client #3's wheelchair was clean and in good repair and client #1 was provided a boot splint. Please see W436. 11. The PD failed to ensure the staff followed the facility menus, offered the clients (#1, #2, #3, #4, #5, #6 and #7) all of the food items on the menu and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/20/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383	

(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
	provided similar food items when substituting menu items. Please see W460. This deficiency was cited on 5/9/14. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-3(a)			
W000186	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) and 3 additional clients (#5, #6 and #7), the facility failed to provide sufficient direct care staff to supervise and care for the clients throughout the day to meet the clients' needs. Findings include: Observations were conducted at the group home on 6/11/14 between 4 PM	W000186	Staff numbers for the evening shift have been increased. The Home Manager will manage the schedule daily and make necessary adjustments to ensure staffing is in place. The PD(QIDP) will monitor the schedule on a weekly basis to ensure staffing is in place. Will be completed by 7-20-14	07/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/20/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383	

(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
	and 7:30 PM. During this observation period there were two direct care staff (staff #1 and staff #2) and the RM (Residential Manager). At the beginning of the observation period staff #2 began giving showers/baths while staff #1 began the evening meal and the RM began the evening medications. During this observation period: __Client #1 walked with a slow unsteady gait with the use of a wheeled walker. Client #1 was non verbal and deaf and would grab the staff to get their attention and then would sign using hand motions to convey her needs. Client #1 stayed in her bedroom, the bathroom and/or was outside smoking during most of the observation period. Client #1 had three scabbed healing areas on her head due to skin picking. __Client #2 walked with a forward lean and a curved back while using a wheeled walker. Client #2's gait was slow and unsteady. Client #2 would occasionally yell out sounds but was otherwise non-verbal. Client #2 required staff redirection, verbal and physical prompting to complete all ADLS (Adult Daily Living Skills) and to participate in leisure activity. Client #2 bit his right wrist several times during the observation period and required frequent staff redirection due to biting. Client #2 required 1:1 (one staff to one client) staff			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/20/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383	

(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
	assistance when eating his evening meal. __Client #3 utilized a tilt in space wheel chair with head and foot rests and a Hoyer (a mechanical lift) for transfers in and out of bed. Client #3 required 1:1 staff supervision while eating his evening meal and staff assistance to meet all of his basic needs. Client #3 required 1:1 staff assistance while eating his evening meal. __Client #4 wore a gait belt and ambulated with a slow unsteady gait. Client #4 required 1:1 staff supervision and hands on assistance when ever ambulating. Client #4 would yell to get the staff's attention when she wanted to go from one room to another or had to use the bathroom and then would have to wait for one of the staff to respond to her yells or requests before getting up. Client #4 required staff assistance and supervision to meet all of her basic needs. __Client #5 required redirection from staff to complete some of her ADLS. __Client #6 was non verbal and required constant staff direction and supervision. Client #6 sat curled up on the living room couch looking out the window and/or walked from the living room to the dining room, wringing her hands and watching. Client #6 was non verbal and required staff verbal and physical prompts to participate in any/all activity. Client #6 required staff redirection and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/20/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383	

(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
	assistance to meet all of her basic daily needs. Client #6 was provided 1:1 staff supervision and assistance while eating her evening meal. __Client #7 required prompting and direction from staff to complete his ADLS and leisure skills. __At 6 PM client #4 was sitting in the recliner in the living room. Client #4 yelled out for staff #2, calling the staff by name and saying, "I want up now." At the same time client #2 was in the kitchen, biting his wrist and yelling. Staff #2 was busy redirecting client #2 from biting his wrist, staff #1 was assisting client #6 and the RM had taken client #3 to his bedroom to change his adult brief. __At 6:10 PM staff #2 went to the living room and escorted client #4 to the dining room for her evening meal. __During the evening meal staff #1 provided 1:1 supervision to client #2, staff #2 provided 1:1 supervision to client #6 and the RM fed client #3. The June 2014 15 minute check records were provided by the RM on 6/16/14 at 3:42 PM via email was reviewed on 6/16/14 at 5 PM .The records indicated clients #1, #2, #3, #4, #6 and #7 were on 15 minute supervision and precautions. The records indicated the 15 minute checks were not being conducted and/or			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/20/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383	

(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
	documented on a regular basis by the staff. Review of the staffing schedules for June 2014 on 6/12/14 at 2 PM indicated two staff working on the weekend of June 7 and 8 and two staff working the evening shift of June 9, 10 and 11, one staff from 2:45 PM to 10:45 PM and one staff from 4 PM to 12 PM with the RM working a "split" shift. The schedule did not indicate the specific hours worked by the RM. During interview with staff #1 on 6/11/14 at 4 PM, staff #1 stated, "This is my first week." Staff #1 indicated he had just started working for the facility and had been in the home for one week. Interview with the RM on 6/11/14 at 4:30 PM indicated the facility had hired more staff and had added more shifts. The RM stated, "There's supposed to be four (staff) in the evening when they're up. We're working on it." The RM indicated the facility was to have four staff when the clients were up throughout the week. The RM stated she was working extra shifts "to pick up the slack." The RM indicated clients #1, #2, #3 and #6 were on 15 minute checks because of seizures, client #4 because of falls risk and client #7 because of AWOL (Absent Without			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/20/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383	

(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
	Leave) behaviors. Email interview with the AD (Area Director) on 6/13/14 at 1:44 PM indicated as of 6/8/14 there were to be four staff in the home during the evening shift when the clients were awake and three staff on the weekend. The AD stated three staff was not the "typical" staffing. The AD indicated the facility was to have four staff in the evening when the clients were awake. This deficiency was cited on 5/9/14. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-3(a)			
W000209	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 3 of 4 sampled clients (#1, #2, and #4), the facility failed to provide evidence of written signature from the client and the clients' legal representatives to ensure the representatives reviewed and participated in the Interdisciplinary Team process and development of the clients' program	W000209	Signed signature pages for individual plans will be attached to the client's plan in Therap. In the absence of legal representatives, the signature page will be mailed to the representative via certified mail. This information will be documented in Therap. The PD(QIDP) will follow-up with the legal representative via mail email or phone when/if the signature	07/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/20/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383	

(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
	plans. Findings include: Client #1's record was reviewed on 6/12/14 at 2 PM. Client #1's record indicated no written signature from client #1 in regard to client #1's ISP (Individual Support Plan) of 4/24/14. Client #2's record was reviewed on 6/12/14 at 4 PM. Client #2's record indicated the client's sister served as client #2's legal representative. Client #2's ISP of 1/21/14 indicated no written signature from client #2's guardian indicating client #2's guardian had participated in and was knowledgeable of client #2's ISP. Client #2's record did not indicate client #2's guardian had participated in the review of client #2's ISP. Client #4's record was reviewed on 6/12/14 at 3:30 PM. Client #4's record indicated client #4's mother served as client #4's legal representative/guardian. Client #4's ISP of 10/3/13 did not indicate written signature indicating client #4's guardian had participated in and was knowledgeable of client #4's ISP. E-mail interview with the AD (Area		sheet is not returned within two weeks of the return receipt date. This information will be documented in Therap. Will be completed by 7-20-14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/20/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383	

(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
	Director) on 6/13/14 at 3 PM indicated the AD and the PD (Program Director) were unable to provide evidence of signatures from the clients and/or the clients' guardians in regard to the involvement and knowledge of the clients' ISPs for clients #1, #2 and #4. This deficiency was cited on 5/9/14. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-4(a)			
W000240	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, record review and interview for 1 of 4 sampled clients (#4), the client's Individualized Support Plan (ISP) failed to address how the staff were to monitor and assist client #4 while showering, toileting and reclining to prevent further injury from falls. Findings include: Observations were conducted at the group home on 6/11/14 between 4 PM and 7:30 PM. During this observation period client #4 wore a gait belt and	W000240	PD(QIDP) will implement a plan for client #4's monitoring while in the shower, toileting and reclining to decrease the risk of falls. PD(QIDP) will train staff on this plan. Will be completed by 7-20-14 Staff will be retrained on documenting 15 minute checks. The Home Manger will review this documentation on a daily basis. PD(QIDP) will do weekly audits to ensure proper documentation. Will be completed by 7-20-14	07/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/20/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383	

(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
	ambulated with a slow unsteady gait. Client #4 required 1:1 (one client to one staff) supervision and hands on assistance whenever ambulating. Client #4 would yell to get the staff's attention when she wanted to go from one room to another or had to use the bathroom and then would have to wait for one of the staff to respond to her yells or requests before getting up. Client #4 sat in the living room recliner alone and unsupervised prior to the evening meal. At 7 PM after eating her evening meal client #4 was escorted to the loveseat in the living room where she laid down and fell asleep. Client #4 remained on the love seat sleeping throughout the remainder of the observation. The facility's reportable and investigative records were reviewed on 6/12/14 at 11 AM. The BDDS (Bureau of Developmental Disabilities Services) report of 5/26/14 report indicated on 5/25/14 at 4:55 PM "[Client #4] was resting on the couch. [Client #4] awoke and decided she wanted to get up. [Client #4] wears a gait belt that staff assist her with while ambulating. [Client #4] did not wait on staff assistance and did not make staff aware she was getting up before she got off the couch. [Client #4] tried to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/20/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383	

(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
	ambulate without staff assistance and she fell. On the way down [client #4] hit her left ear on the entertainment center. [Client #4] sustained a laceration to her left ear lobe." __The 5/25/14 investigative summary of client #4's injury of 5/25/14 indicated interviews from two staff (#3 and the HM - home manager). The investigative summary indicated staff #3 was changing another client in the bathroom. The summary indicated the HM reported she was in the bedroom changing a client. "Was not observed. Was in bedroom changing another client and heard her (client #4) yell. She (client #4) was sleeping when I (HM) went into the bedroom. When I (HM) got to the living room she (client #4) was sitting on the floor beside the loveseat which she had been sleeping on and there was blood on the floor and the entertainment center. Her (client #4's) earlobe was split and open area behind her ear." __The 6/10/14 follow up BDDS report indicated "[Client #4] appears to be doing well at this time. she has had no complications from the injury or stitches. She has since had her stitches removed and has not had any complications from the stitches being removed. [Client #4] followed-up with her PCP and is currently being evaluated for a prescription for a helmet to safe guard her			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/20/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383	

(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
	head." The BDDS report of 2/22/14 indicated on 2/22/14 at 8:29 AM "When getting out of bed, [client #4] fell on her right side. She sustained no injury. Plan to Resolve: Staff continue to monitor. [Client #4] will be placed on programming to let staff assist her in getting out of bed in the mornings." The BDDS report of 10/9/13 indicated on 10/8/13 at 6:40 PM "Staff was assisting [client #4] in the shower. [Client #4] does not have a steady gait, therefore, she [client #4] uses a gait belt. The gait belt cannot be utilized on bare skin, so [client #4] could not use her gait belt when she was in the shower. The staff was trying to assist [client #4] with drying off when [client #4] got upset without staff assistance. The shower floor was wet and [client #4] slipped and fell. She [client #4] hit her buttocks and then hit her head on the wall. There was a laceration on [client #4's] head approximately 1.5 inches long. The ER (Emergency Room) doctor said [client #4] was coherent to time and place and did not require a CT scan (an X-ray) or any other imaging services. The doctor put four staples in the laceration to close it and assist with the healing process. She [client #4] did not require any restrictions and appears to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/20/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383	

(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
	be doing well at this time. Plan to Resolve. [Client #4] was evaluated by a cardiologist to determine if the falls could be something associated with any issues a cardiologist could determine. The cardiologist did not believe [client #4's] falls were due to any cardiology issues. [Client #4] was evaluated by a physical therapist on 5/24/13 and she [client #4] was to step over 6 inches, ambulate on level stairs, grass, and curbs. She [client #4] was evaluated with a walker and she showed excessive forward lean and carried the walker, so it was determined a walker would not suit her needs. Due to [client #4] having no loss of balance at PT (Physical Therapy) it was determined that her ambulation needs would be met through a gait belt.... [Client #4] is currently on formal programming to help her understand it is important for her to wait for staff assistance before ambulating or standing. Staff will continue to work with [client #4] on this program, assist her with her ambulation needs, and monitor the injury for any signs of worsening, infection and etc." The BDDS report of 8/22/13 indicated on 8/22/13 at 3:30 PM "[Client #4] was sitting on the picnic during a community outing. She [client #4] was playing Bingo and had won a prize. [Client #4] went to stick the prize in her pockets and lost her			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/20/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383	

(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
	balance and fell backwards. Staff was able to get her [client #4] in enough time to cushion her fall. Staff was not able to prevent the fall completely, but she did not hit the ground hard. [Client #4] hit her head, but it was not severe. There was no bump on her head nor did it bleed. [Client #4] hit her leg on the top of the picnic table and caused a superficial scrape on her left leg. The scrape is approximately 3.5 inches in length and only required basic first aid. Neuro checks were performed on [client #4] the rest of the evening and all through the night.... Plan to Resolve. [Client #4] will have a fold up chair with her at all times that has a back on it in order to prevent her from losing her balance and falling backwards." Client #4's record was reviewed on 6/12/14 at 3:30 PM. __Client #4's ISP dated 10/3/13 indicated "Staff assists [client #4] with a gait belt when she is up ambulating. She [client #4] is on 15 min (minute) checks." The ISP indicated client #4 requires staff prompting and physical assistance when taking a shower to regulate the water temperature and to ensure client #4 washes thoroughly. __Client #4's Falls Risk Plan dated 5/9/14 indicated client #4 "utilizes a gait belt. She [client #4] should be wearing			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM OCCAZIO LLC	10311 E JACKSON SELMA, IN 47383

(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
	this at all times and staff should be assisting while ambulating. The environment should be kept clear of hazards. Staff are to assist [client #4] as needed with ambulation (walking)." __Client #4's ISP and/or Falls Risk Plan did not include how the staff were to monitor and assist client #4 while in the shower and/or toileting to prevent falls. Client #4's ISP and/or Risk Plan did not include how the staff were to supervise client #4 while in bed, reclining and/or lying down. __Client #4's record indicated no changes in client #4's ISP and/or risk plan after client #4's fall on 5/25/14. Interview with staff #2 on 6/11/14 at 4:30 PM indicated client #4 wore a gait belt at all times and was on 1:1 staff supervision while ambulating. Staff #2 indicated client #4 was on 15 minute checks and could be left alone in the living room, bathroom and/or her bedroom if the client was in bed. Interview with the RM on 6/11/14 at 6:30 PM stated client #4 "frequently" would lay on the couch and/or love seat in the living room after eating her evening meal and would fall asleep. The RM indicated client #4 was to wear a gait belt and was to be on 1:1 supervision with hands on assist while ambulating. The RM			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/20/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383	

(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
	indicated the staff were to check on client #4 every 15 minutes. Interview with the PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) on 6/12/14 at 2 PM stated client #4's ISP/Risk plan "should include how the staff were to supervise client #4 throughout the day." The PD stated she was new to the facility and this was her first week in the group home and she was "just getting to know them (the clients)." Interview with the AD on 6/12/14 at 3 PM indicated client #4 had seen her physician and had received an order for a helmet to protect client #4 from head injury due to falls. When asked how are the staff to supervise/monitor client #4 to prevent further injury from falls, the AD indicated client #4 was on 15 minute checks by the staff and client #4 was to be assisted with all ambulation. The AD indicated client #4 was to request assistance when getting up. The AD indicated the level of staff supervision for client #4 had not changed after client #4's fall on 5/25/14. This deficiency was cited on 5/9/14. The facility failed to implement a systemic plan of correction to prevent recurrence.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM OCCAZIO LLC	10311 E JACKSON SELMA, IN 47383

(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
	9-3-4(a)			
W000252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. Based on record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), the facility failed to ensure the staff documented the clients' program data as directed. Findings include: Review of the 15 minute check sheets for clients #1, #2, #3 and #4 for June 8th through June 15, 2014 indicated: __No documentation for client #1 for June 8, 10 and 11, 2014 and incomplete documentation for June 9, 13, 14 and 15, 2014. __No documentation for client #2 for June 8, 9, 10 and 11, 2014 and incomplete documentation for June 12, 13, 14, and 15, 2014. __No documentation for client #3 for June 8, 9 and 11, 2014 and incomplete documentation for June 10, 12, 13, 14 and 15, 2014. __Incomplete documentation for client #4 for June 8, 9, 10, 11, 12, 13, 14 and	W000252	Staff will be retrained on documenting 15 minute checks. The Home Manger will review this documentation on a daily basis. PD(QIDP) will do weekly audits to ensure proper documentation. Will be completed by 7-20-14	07/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/20/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383	

(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
	15, 2014. Interview with the RM (Residential Manager) on 6/11/14 at 6:30 PM indicated clients #1, #2, #3 and #4 were on 15 minute checks and the staff were to check on and document the clients' activity every 15 minutes throughout the day on each of the clients' 15 minute check sheets. The RM stated, "We need to work on that." This deficiency was cited on 5/9/14. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-4(a)			
W000323	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 2 of 4 sampled clients (#1 and #4), the facility failed to ensure client #1's hearing and client #4's vision were evaluated annually. Findings include: Client #1's record was reviewed on 6/12/14 at 2 PM. Client #1's vision	W000323	Home Manager will make an appointment for client #1 to have a hearing evaluation with the PCP or audiologist. Home Manager will document the appointment and results in Therap. Will be completed by 7-20-14 Home Manager will make an appointment for client #4 to have a vision screening with the PCP or optometrist. Home Manager will document the appointment	07/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/20/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383	

(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
	evaluation of 10/26/12 indicated "Hyperopia (farsighted) Astigmatism Presbyopia (blurred vision) and right Exotropia (an eye that turns outward). No eyewear advised. This has been tried in the past with behavior modification and she always breaks them." Client #1's record indicated no vision evaluation since the one of 10/26/12. Client #4's record was reviewed on 6/12/14 at 3:30 PM. Client #4's hearing evaluation of 10/17/12 indicated "probable mild hearing loss present, however hearing status is adequate and appropriate for communication purposes." Client #4's 11/26/13 annual physical examination indicated no hearing evaluation. Client #4's record indicated no hearing evaluation since the evaluation of 10/17/12. E-mail interview with the facility RN on 6/13/14 at 2:45 PM indicated client #4's most current hearing evaluation was 10/17/12. The RN indicated hearing evaluations were conducted every three years and client #4's hearing was not due until 2015. The facility nurse indicated client #1's most current eye evaluation was 10/26/12. The RN indicated the RM (Residential Manager) was responsible for making the clients' medical appointments.		and results in Therap. Will be completed by 7-20-14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/20/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383	

(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
	Email interview on 6/13/14 at 3:40 PM with the AD (Area Director) indicated the home manager was responsible for making all appointments with the oversight from the PD/QIDP. This deficiency was cited on 5/9/14. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-6(a)			
W000331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 1 of 4 sampled clients (#1), the facility nursing services failed to develop and implement a specific plan of care in regard to client #1's wounds due to self injurious behaviors of skin picking, to assess and monitor client #1's wounds and to ensure the staff conducted body assessments twice daily and recorded descriptive assessments of their findings in the client's record. Findings include: 1. Observations were conducted at the group home on 6/11/14 between 4 PM and 7:30 PM. Client #1 ambulated	W000331	Nursing services will develop and implement a plan of care to address client #1's wounds due to skin picking. Will be completed by 7-20-14 Staff will be retrained by the PD(QIDP) to be descriptive in their assessments of wounds and skin checks. Home Manager will audit assessments weekly. Will be completed by 7-20-14	07/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/20/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383	

(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
	independently with a seated wheeled walker, was non-verbal and used sign language for communication. Client #1 would reach out and smack or grab at the staff to get their attention when she needed something. At 4:57 PM client #1 was in the medication room and received her PM medications from the RM (Residential Manager). The RM indicated client #1 had three scabbed areas on her head the staff were still keeping an eye on. Client #1's record was reviewed on 6/12/14 at 2 PM. __Client #1's Office Visit with the dermatologist dated 4/25/14 indicated "...PT (patient) has problems with chronic picking, her body is better. She (client #1) is now picking at her scalp. The symptoms were first noticed several months ago and are continuous. Currently symptoms include irritation, redness, pain.... She has been treated before for psoriasis and now she has some psoriasis on her scalp as well as some secondary Factitial (self-inflicted) excoriation. She has 2 ulcers on the scalp which she picks. Recommend continuing treatment with Selsun shampoo and Clobetasol (to treat various skin disorders including eczema and psoriasis) solution to the scalp as before. We will increase her Hydroxyzine (an antihistamine) from 10-25 mg			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/20/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383	

(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
	(milligrams) 3 times a day. And use some Mupirocin an antibiotic) ointment on the open areas twice a day. Return in 7 weeks." __Client #1's BSP (Behavior Support Plan) of 6/5/14 indicated client #1 had a targeted behavior of skin picking. The plan indicated the staff were to: 1. Ask client #1 to stop skin picking. 2. Counsel client #1 that she could harm herself. 3. Re-direct client #1 to another activity. __Client #1's updated 5/9/14 Risk Plan for skin integrity indicated client #1 "has risks involved with use of adaptive devices along with behavioral concerns with self-injurious behavior (skin picking).... [Client #1] has a support plan that addresses self-injurious behavior (skin picking). She (client #1) is followed quarterly by a psychiatrist. Staff are to complete a skin check BID (twice a day) and record their findings in Therap (a computer program)." __Client #1's June 2014 MAR (Medication Administration Record) indicated the staff were to do a skin assessment twice a day (6 AM and 6 PM) as a nursing measure and the RM (Residential Manager) was to be notified of any abnormal findings and/or			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/20/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383	

(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
	concerns. Client #1's Skin/Wound assessments by the direct care staff for April through June of 2014 indicated: 6/11/14 at 10:23 PM "picking at scabs/nothing new/ointment applied." 6/10/14 at 8:22 PM "picking at scabs, nothing new, ointment applied." 6/09/14 at 9:40 PM "picking at scabs, nothing new, ointment applied. 6/07/14 at 7:41 PM "open areas on head." 6/06/14 at 11:14 PM "open areas on head. Continue to monitor." 6/05/14 at 9:18 PM "picking scabs/nothing new/ointment applied." 6/04/14 at 8:18 PM "still picking scabs, nothing new, ointment applied." 6/03/14 at 8:43 PM "still picking at scabs, nothing new to report, ointment applied." 6/02/14 at 8:59 PM "still picking at scabs, nothing new, ointment applied." 6/01/14 at 10:37 PM "Nothing to report." 5/31/14 at 10:50 PM "Nothing to report." 5/30/14 at 9:38 PM "still picking at scabs, nothing new, ointment applied." 5/29/14 at 9:22 PM "still picking at scabs, nothing new, ointment applied." 5/28/14 at 7:37 PM "still picking at scabs, nothing new, ointment applied." 5/28/14 at 5:43 AM "open areas on head." 5/27/14 at 5:43 AM "open areas on			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/20/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383	

(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
	head." 5/27/14 at 7:41 PM "still picking scabs, nothing new, ointment applied." 5/26/14 at 8:37 PM "still picking at scabs, nothing new, ointment applied." 5/25/14 at 9:22 PM "Nothing to report." 5/24/13 at 7:30 AM "open areas on top of head-two places are open." 5/23/14 at 8:57 PM "still picking scabs, nothing new, ointment applied." 5/22/14 at 8:38 PM "still picking scabs, nothing new, ointment applied." 5/21/14 at 7:56 PM "still picking at scabs/nothing new/ointment applied." 5/20/14 at 9:42 PM "still picking, nothing new, ointment applied." 5/19/14 at 9:29 PM "nothing new, still picking at scabs, ointment applied." 5/17/14 at 3:12 PM "Areas on head that she (client #1) continues to pick are looking a bit better. Area on left leg below knee is scabbed over and was not picked at this time today. Nothing else to report." 5/16/14 at 8:14 PM "still picking at scabs, nothing new, ointment applied." 5/15/14 at 9:13 PM "still picking scabs, nothing new, ointment applied." 5/14/14 at 7:59 PM "scalp area dry and scabbed over." 5/13/14 at 9:16 PM "still picking scabs, nothing new, ointment applied." 5/12/14 at 9:16 PM "still picking scabs, nothing new, ointment applied."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM OCCAZIO LLC	10311 E JACKSON SELMA, IN 47383

(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
	5/11/14 at 11:20 PM "client has been picking at the sore on her head." 5/10/14 at 7:11 AM "no problems head sores dry." 5/10/14 at 8:31 PM "no problems." 5/09/14 at 8:41 PM "still picking at scabs, nothing new, ointment applied." 5/08/14 at 9:11 PM "still picking at scabs, nothing new, ointment applied." 5/07/14 at 8:31 PM "[client #1] is still picking at scabs, nothing new to report, ointment applied." 5/06/14 at 9:18 PM "still picking at scabs, ointment applied, nothing new." 5/05/14 at 6:30 AM "Continues to pick at any and every scab on her body. One on her leg and 3 on her head." 5/05/14 at 7:31 AM "two areas on head open." 5/05/14 at 8:45 PM "still picking her head, nothing new, ointment applied." 5/04/14 at 8:17 AM "open areas on scalp. No other problems." 5/04/14 at 9:26 PM "picking sore on her head." 5/03/14 at 8:47 PM "no problems." 5/02/14 at 6:30 AM "no problem areas." 5/01/14 at 9:34 PM "still picking at head, nothing new, ointment applied." 4/30/14 at 8:13 PM "still picking at scabs on her head, nothing new, ointment applied." 4/29/14 at 7:42 AM "no problems today." 4/29/14 at 8:22 PM "nothing new, still			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM OCCAZIO LLC	10311 E JACKSON SELMA, IN 47383

(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
	picking at the scabs on her head, ointment applied." 4/28/14 at 8:49 PM "ointment applied, still picking, nothing new." 4/26/14 at 8:30 AM "no problems no open areas." 4/26/14 at 8:13 PM "no problems." 4/25/14 at 8:35 PM "still picking, ointment applied, nothing new." 4/24/14 at 9:41 PM "still picking, nothing new, ointment applied." 4/23/14 at 10:10 PM "still picking, nothing new, ointment applied." 4/22/14 at 5:42 AM "red areas on head dry." 4/22/14 at 8:47 PM "still picking, nothing new, ointment applied." 4/21/14 at 8 PM "nothing new, still picking, ointment applied." 4/20/14 at 11:34 PM "2 open areas on the top of her head that she continues to pick at. She also opened a healed area on her left leg just below the knee." 4/19/14 at 9:20 PM "still has 2 open areas on head that she continues to pick. No other open areas." 4/18/14 at 8:50 PM "still picking, nothing new to report, ointment applied." 4/17/14 at 8:14 PM "still picking at scabs on her head, nothing new, ointment applied." 4/16/14 at 10:40 PM "still picking at scabs on head, ointment applied." 4/15/14 at 4:41 PM "continues to pick at			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/20/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383	

(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
	the wounds on her scalp. No other open wounds. A scab on leg that she previously picked." 4/15/14 at 9 PM "Continues to pick at scabs on her head, nothing new, ointment applied." 4/14/14 at 7:56 PM "still picking at head." 4/13/14 at 8:27 PM "clients (sic) been picking with the wound on her head." 4/12/14 at 8:29 PM "client has been messing with the wound on her head today." 4/11/14 at 9:47 PM "still picking at scabs, ointment applied, nothing new." 4/11/14 at 6 AM "[Client #1] has a sore at the crown and one toward the front of her hair where she continues to pick. No other sores/bruises at this time." 4/10/14 6 AM "[Client #1] continues to have 2 sores on her head that she continues to pick." 4/9/14 at 6:37 AM "clear skin no open areas." 4/09/14 at 8:17 PM "[Client #1] has been picking at the scabs on her head." 4/08/14 at 7:23 PM "still picking at her head, nothing new, ointment applied." 4/7/14 at 7:48 PM "still picking, ointment applied, nothing new." 4/6/14 at 8 AM "skin clear no problems." 4/4/14 at 9:07 PM "nothing new, still picking at scabs on her head, ointment applied."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/20/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383	

(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
	4/03/14 at 8:35 PM "still picking at her head, ointment applied, nothing new." 4/02/14 at 9:39 PM "still picking the scabs on her head, ointment applied, nothing new." 4/1/14 at 9:15 PM "still picking her head, nothing new, ointment applied." Client #1's record indicated: __The RN did not assess and/or monitor client #1's wounds due to skin picking. __The staff did not conduct and/or document skin assessments two times a day as indicated on the MAR and as instructed by the facility RN. __The staff did not document the size shape and/or location of the client's wounds. __The RN did not develop and/or implement a specific plan of care to indicate how the staff were to assess, monitor and care for client #1 in regard to the client's behavior of skin picking, what was to be reported to the RN and/or what the staff were to document. Interview with the RM (Residential Manager) on 6/11/14 at 4:57 PM indicated client #1 had been picking at the top of her head "for quite a while" and had "a couple of scabbed areas" on her head the staff were monitoring. The RM indicated client #1 was seeing a dermatologist and the staff were putting a			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/20/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383	

(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
	cream on the area. The RM assessed client #1's head with two scabbed healing areas noted with no open sores noted. One of the areas was approximately two - three centimeters in circumference. Telephone interview with the RN on 6/20/14 at 12 PM indicated she did not do client #1's quarterly assessments. The RN indicated the assessments were done by the client's PCP (Primary Care Physician) quarterly and client #1 saw a dermatologist as prescribed by the PCP. The RN indicated the staff were to monitor client #1's skin twice daily and were to report anything out of the normal or any issues with the RM. The RN indicated she reviewed the client's monthly health data via her computer and made suggestions as needed. The RN indicated she did not visually assess client #1's injuries on her head that were caused from the SIB (Self Injurious Behaviors) of skin picking. The RN stated the staff were to document all health data as directed in the client's MAR and were to write a descriptive assessment of "all injuries" in Therap (the computer program used by the facility to record the clients' data). The RN stated, "I know we need to work on that." This deficiency was cited on 5/9/14. The facility failed to implement a systemic			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/20/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383	

(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
	plan of correction to prevent recurrence. 9-3-6(a)			
W000436	483.470(g)(2) SPACE AND EQUIPMENT 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. Based on observation, interview and record review for 2 of 4 sample clients with adaptive equipment (#1 and #3), the facility failed to ensure client #3's wheelchair was clean and in good repair and client #1 was provided a boot splint. Findings include: Observations were conducted at the group home on 6/11/14 between 4 PM and 7:30 PM. Client #3 sat in a tilt in space wheelchair. Both of the armrests on client #3's wheelchair were torn and the padding was exposed. Client #3's wheelchair had dried crumbs of unidentifiable substance and dirt on the seat and the wheels of the wheelchair. Review of client #3's June 2014 MAR (Medication Administration Record) on	W000436	Staff will be retrained to clean client #3's wheelchair on a daily basis and document in the MAR. Home Manager will audit the MAR daily to ensure daily cleaning of the wheelchair. Will be completed by 7-20-14 Home Manager will schedule an appointment for client #1's boot splint. Home Manager will inform the PD(QIDP) of this appointment. The PD(QIDP) will follow-up with the Home Manager after the appointment. Will be completed by 7-20-14	07/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/20/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383	

(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
	6/13/14 at 9 AM indicated "Staff will deep clean [client #3's] wheelchair from top to bottom daily. This includes all wheelchair accessories (i.e.: harness, foot rests) to ensure wheelchair cleanliness." The June MAR indicated the staff had not cleaned client #3's wheelchair June 1, 2, 5, 6, 7, 8, 9, 10 and 11, 2014. During interview with staff #2 on 6/11/14 at 5 PM, staff #2 stated client #3's wheelchair was to be cleaned "nightly, but it doesn't look like it's been done." Staff #2 stated client #3's armrests were "torn and cracked." Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 6/12/14 at 3 PM stated the staff were to maintain and clean the clients' adaptive equipment as indicated in the clients' MARs and "all adaptive equipment" was be in good repair. Email interview with the AD (Area Director) on 6/13/14 at 2:43 PM indicated the clients' adaptive equipment was to be maintained and in good repair. 2. Client #1's record was reviewed on 6/12/14 at 2 PM. Client #1's February, March, April and June 2014 MARs indicated client #1 was to be provided a boot splint to wear from 8 AM - 12 PM			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM OCCAZIO LLC	10311 E JACKSON SELMA, IN 47383

(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
	for Cerebral Palsy. The MARs indicated client #1 had not been provided the boot splint from February 1, 2014. Interview with the RM (Residential Manager) on 6/11/14 at 5 PM indicated client #1's boot splint was "still broken." The RM indicated the facility was trying to have client #1 reassessed with PT (Physical Therapy) for the need for the brace. Email interview with the AD (Area Director) on 6/13/14 at 1:59 PM indicated "We had some issues with the PT (Physical Therapy) evaluation. It was rescheduled by the PT (Physical Therapist) and we were not notified. [Residential Manager] responded with the following: A new PT eval was ordered for her regarding those splints. I (the RM) went to that appt. (appointment) this past Wednesday 6/11 (2014) and when we arrived were told that the appt. had been cancelled.... I (the RM) then called the doctor and had them send through another referral...." This deficiency was cited on 5/9/14. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-7(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM OCCAZIO LLC	10311 E JACKSON SELMA, IN 47383

(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
W000460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, interview and record review for 4 of 4 sampled clients (#1, #2, #3 and #4), the facility failed to ensure the staff offered the clients all of items on the menu and provided similar food items when substituting food. Findings include: Observations were conducted at the group home on 6/11/14 between 4 PM and 7:30 PM. During this observation period the clients (#1, #2, #3, #4, #5, #6 and #7) were served and ate meatloaf, baked potatoes, creamed corn and canned pears for their evening meal. The clients did not receive bread for their evening meal. Review of the undated "Regular Fall/Winter" facility menu on 6/11/14 at 5 PM indicated the clients were to have the following for their evening meal: 2 to 3 ounces of barbeque chicken (skinless) 1/2 cup of low fat macaroni and cheese 1 cup of cooked cabbage 1 slice of bread 1 small baked apple.	W000460	PD(QIDP) will train the Home Manager on the menu and grocery list and supplying client #7's snack box. PD(QIDP) will do weekly checks to ensure all ingredients are in the home per the menu and that client #7's snack box is being supplied. Will be completed by 7-20-14 Home Manager will train staff on the menus, how to follow them and review the food substitution lists. The Home Manager will review the menu substitution list on a weekly basis. The Home Manager will perform meal observations weekly to ensure the menu is being followed and substitutions are being made correctly where applicable. The PD(QIDP) will do bi-monthly meal observations to ensure the menu is being followed and that food substitutions are made correctly. Will be completed by 7-20-14	07/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM OCCAZIO LLC	10311 E JACKSON SELMA, IN 47383

(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
	Review of the facility June 2014 substitution record on 6/11/14 at 5 PM indicated the staff had substituted the meatloaf for the chicken, the baked potatoes for the macaroni and cheese and the creamed corn for the cabbage. Interview with staff #1 on 6/11/14 at 5 PM indicated the items on the menu were substituted because the facility did not have the items on the menu to offer the clients. Staff #1 indicated the facility was out of bread and did not have a green vegetable/non starchy substitute for the cabbage that was on the menu. Interview with the RM (Residential Manager) on 6/11/14 at 5:30 PM indicated she did the grocery shopping for the home and stated, "I just haven't had the time to do the shopping." The RM indicated she had planned on going grocery shopping that evening but was unable to go. The RM indicated the staff were to follow the facility menu, offer all of the food on the menu and were to provide similar food items when substituting food. This deficiency was cited on 5/9/14. The facility failed to implement a systemic plan of correction to prevent recurrence.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM OCCAZIO LLC	10311 E JACKSON SELMA, IN 47383

(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
W009999	9-3-8(a)	W009999	The statement of deficiencies did not have a citation for W-9999.	07/20/2014