

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G251	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/02/2012
NAME OF PROVIDER OR SUPPLIER OCCAZIO INC			STREET ADDRESS, CITY, STATE, ZIP CODE 511 COUNTRY CLUB LN ANDERSON, IN 46015		
(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	
W0000	<p>This visit was for investigation of complaint #IN00117915.</p> <p>Complaint #IN00117915 - Substantiated, Federal and state deficiencies related to the allegations are cited at W149, W153, and W154.</p> <p>Dates of Survey: October 30, 31, and November 1, and 2, 2012.</p> <p>Facility Number: 000771 Provider Number: 15G251 AIMS Number: 100243430</p> <p>Surveyor: Susan Eakright, Medical Surveyor III/QMRP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review was completed on 11/7/12 by Tim Shebel, Medical Surveyor III.</p>	W0000			

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

TITLE

(X6) DATE

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

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W0149	<p>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.</p> <p>Based on record review and interview for 1 of 3 sampled clients (client B) for 1 non reported allegation of neglect, the facility neglected to implement the facility's policy and procedure to report and to thoroughly investigate client B's incident of being left home alone.</p> <p>Findings include:</p> <p>On 10/30/12 at 2pm, the facility's BDDS Reports were reviewed from 07/01/12 through 10/30/12. There was no BDDS Report for the allegation of neglect for client B being forgotten and left home alone by the facility staff on 8/10/12.</p> <p>On 10/31/12 from 6:40am until 7:30am, observation and interview were completed at the group home. At 6:50am, client B stated he was "left home alone" in August, 2012. Client B stated he thought the duration "was a couple of hours." Client B stated "I was asleep. I never went on the van (with the staff and other clients). I was a little bit scared when I was left home alone." At 7:05am, Facility Staff (FS) #2 indicated client B was an accurate reporter of information.</p>	W0149	<p>W 149 Staff Treatment of Clients</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · Staff members who were determined to be involved in the incident involving Client B have all been counseled. · Staff will be retrained on Occazio's policy #2105 Abuse, Neglect and Exploitation at their staff meeting on 11-27-12. · All staff will be trained on Client B's supervision needs. · The IDT will review Client B's supervision needs and update his IPOP assessment as needed. · Staff will be trained on proper ways to communicate with the other staff members of the house and the RC regarding the events happening at the home 	12/02/2012	

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	<p>FS #2 stated client B was "left home alone around the first week of August, 2012." FS #2 stated "I was written up and told it cannot happen again." At 7:10am, FS #4 indicated client B was an accurate reporter of information.</p> <p>Confidential Interview #1 (CI #1) indicated client B was an accurate reporter of information. CI #1 stated client B "was left home alone on 8/10/12 when he was ill." CI #1 stated client B was in bed asleep on the morning of 8/10/12, the (group home) staff (two staff from night shift and two staff from day shift) left in the van with the other clients for transport to the workshop, and a staff found client B "in bed later in the afternoon" after the staff returned to the group home. CI #1 stated the clients leave for workshop at "around 7:30am" daily.</p> <p>Confidential Interview #2 (CI #2) stated client B was "left home alone a few hours" on 8/10/12 and the incident was not reported according to policy and procedure or state law.</p> <p>On 10/31/12 at 10:20am, the facility's Workshop Attendance Record for client B was reviewed and indicated client B did not attend workshop on 8/10/12.</p>		<p>and with the residents at their staff meeting on 11-27-12.</p> <ul style="list-style-type: none"> · Programming will be implemented for Client B on reporting abuse, emergency contacts, and his supervision needs. <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · Staff will be retrained on Occazio's policy #2105 Abuse, Neglect and Exploitation at their staff meeting on 11-27-12. · Staff will be trained on proper ways to communicate with the other staff members of the house and the RC regarding the events happening at the home and with the residents at their staff meeting on 11-27-12. · The clients IPOP assessments will be reviewed and updated as their needs change. 				

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	<p>On 10/30/12 at 10:40am, the facility's Personnel Files were reviewed with the Area Director (AD). At 10:40am, Facility Staff (FS) #1, FS #2, and FS #3's personnel files indicated an entry into each personnel file on 8/10/12 "Counseling Summary, Written Warning...On 8/10/12 failure to communicate with co workers resulted in a situation that could have potentially been considered neglectful. Understand that another incident of failure to communicate information to RC (Residential Coordinator) and co workers will result in termination of your employment."</p> <p>On 10/30/12 at 11:20am, an interview with the Area Director (AD) was conducted. The AD stated the allegation of neglect regarding client B's incident on 8/10/12 was "not reported (to BDDS) because [client B] could be left home alone for a short period of time at [client B's] mothers home." The AD stated the incident on 8/10/12 "was not planned to leave [client B] home alone (and) we have not determined how long [client B] was at home alone." When asked if staff neglected to supervise client B and know his whereabouts, the AD stated "We should always know where our clients are and we did not supervise him (on 8/10/12)." The AD stated "no one knew"</p>		<p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · Staff will be retrained on Occazio's policy #2105 Abuse, Neglect and Exploitation at their staff meeting on 11-27-12. · Staff will be trained on proper ways to communicate with the other staff members of the house and the RC regarding the events happening at the home and with the residents at their staff meeting on 11-27-12. · The clients IPOP assessments will be reviewed and updated as their needs change. <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · The RC will monitor on a daily basis when they are in the home. · The Program Specialist will monitor as they complete their audits. 				

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	<p>client B was at home alone on 8/10/12. The AD further indicated staff neglected to follow the abuse/neglect policy and procedure on reporting and investigating allegations of neglect. The AD indicated no investigation was completed for client B's 8/10/12 incident.</p> <p>On 10/30/12 at 2:30pm, the facility's policy and procedure for 1/1/2011 "Suspected Abuse, Neglect, & Exploitation Reporting" was reviewed. The policy and procedure indicated the agency prohibited abuse, neglect, and/or mistreatment and all employees are responsible to immediately report incidents of abuse, neglect, and/or mistreatment. The policy and procedure indicated "Neglect: the failure to provide the proper care for a resident/consumer, in a timely manner, causing the resident/consumer undue physical or emotional stress or injury; unreasonable delays in providing appropriate services...Reporting Suspected Abuse, Neglect, and Exploitation...The employee alleging that suspected abuse, neglect, and/or exploitation has occurred must complete the [Incident Report] on the same day..." The policy and procedure indicated the incident must be investigated.</p> <p>On 10/30/12 at 2:30pm, a review was</p>						

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	<p>conducted of the 10/2005 "Bureau of Developmental Disability Services Policy and Guidelines." The BDDS policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs although sources of such support are available and offered and such failure results in physical or psychological harm to the individual." The policy indicated the incident should be reported to the administrator and to BDDS in accordance with state law.</p> <p>This federal tag relates to complaint #IN00117915.</p> <p>9-3-2(a)</p>				

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W0153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview for 1 of 3 sampled clients (client B) for 1 non reported allegation of neglect, the facility failed to report an allegation of neglect for client B's incident of being left home alone.</p> <p>Findings include:</p> <p>On 10/30/12 at 2pm, the facility's BDDS Reports were reviewed from 07/01/12 through 10/30/12. There was not a BDDS Report for client B left home alone by the facility staff on 8/10/12.</p> <p>On 10/31/12 from 6:40am until 7:30am, observation and interview were completed at the group home. At 6:50am, client B stated he was "left home alone" in August, 2012. Client B stated he thought the duration "was a couple of hours." Client B stated "I was asleep. I never went on the van (with the staff and other clients). I was a little bit scared when I was left home alone." At 7:05am, Facility Staff (FS) #2 indicated client B</p>	W0153	<p>W 153 Staff Treatment of Clients The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>1. What corrective action will be accomplished? · Staff will be retrained on Occazio's policy #2105 Abuse, Neglect and Exploitation at their staff meeting on 11-27-12. · Staff will retrained on the incident reporting guidelines. · The importance of notifying the administrator immediately was reviewed with the RC and ARC on 11-19-12. · The importance of notifying their supervisor and the administrator immediately was reviewed with the staff at the Country Club Lane group home at the staff meeting on 11-27-12. · All staff members who fail to notify the administrator immediately will face disciplinary action per Occazio's policy regarding abuse, neglect and exploitation. 2. How will we identify other residents having the potential to be affected by</p>	12/02/2012	

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	<p>was an accurate reporter of information. At 7:10am, FS #4 indicated client B was an accurate reporter of information.</p> <p>Confidential Interview #1 (CI #1) indicated client B was an accurate reporter of information. CI #1 stated client B "was left home alone on 8/10/12 when he was ill." CI #1 stated client B was in bed asleep on the morning of 8/10/12, the staff left in the van with the other clients for transport to the workshop, and a staff found client B "in bed later in the afternoon" after the staff returned to the group home. CI #1 stated the clients leave for workshop at "around 7:30am" daily.</p> <p>Confidential Interview #2 (CI #2) stated client B was "left home alone a few hours" on 8/10/12 and the incident was not reported according to state law.</p> <p>On 10/31/12 at 10:20am, the facility's Workshop Attendance Record for client B was reviewed and indicated client B did not attend workshop on 8/10/12.</p> <p>On 10/30/12 at 11:20am, an interview with the Area Director (AD) was conducted. The AD stated the allegation of neglect for client B's incident on 8/10/12 was "not reported (to BDDS) because [client B] could be left home</p>		<p>the same deficient practice and what corrective action will be taken? · All residents have the potential to be affected by the same deficient practice. · Staff will be retrained on Occazio's policy #2105 Abuse, Neglect and Exploitation at their staff meeting on 11-27-12. · The importance of notifying the administrator immediately was reviewed with the RC and ARC on 11-19-12. · The importance of notifying their supervisor and the administrator immediately was reviewed with the staff at the Country Club Lane group home at the staff meeting on 11-27-12. · All staff members who fail to notify the administrator immediately will face disciplinary action per Occazio's policy regarding abuse, neglect and exploitation. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: · Staff will be retrained on Occazio's policy #2105 Abuse, Neglect and Exploitation at their staff meeting on 11-27-12. · The importance of notifying the administrator immediately was reviewed with the RC and ARC on 11-19-12. · The importance of notifying their supervisor and the administrator immediately was reviewed with the staff at the Country Club Lane group home at the staff meeting on 11-27-12. · All staff members who fail to notify the administrator</p>				

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	<p>alone for a short period of time at [client B's] mothers home." The AD stated the incident on 8/10/12 "was not planned to leave [client B] home alone (and) we have not determined how long [client B] was at home alone." When asked if staff failed to supervise client B and know his whereabouts, the AD stated "We should always know where our clients are and we did not supervise him (on 8/10/12)." The AD stated "no one knew" client B was at home alone on 8/10/12.</p> <p>This federal tag relates to complaint #IN00117915.</p> <p>9-3-2(a)</p>		<p>immediately will face disciplinary action per Occazio's policy regarding abuse, neglect and exploitation. 4. How will the corrective action be monitored to ensure the deficient practice will not recur? · The RC will monitor on a daily basis when they are in the home. · The Program Specialist will monitor as they complete their audits.</p>		

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W0154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 1 of 3 sampled clients (client B) for 1 non reported allegation of neglect, the facility failed to thoroughly investigate client B's 8/10/12 incident of being left home alone.</p> <p>Findings include:</p> <p>On 10/30/12 at 2pm, the facility's BDDS Reports were reviewed from 07/01/12 through 10/30/12. There was not a BDDS Report for client B left home alone by the facility staff on 8/10/12.</p> <p>On 10/31/12 from 6:40am until 7:30am, observation and interview were completed at the group home. At 6:50am, client B stated he was "left home alone" in August, 2012. Client B stated he thought the duration "was a couple of hours." Client B stated "I was asleep. I never went on the van (with the staff and other clients). I was a little bit scared when I was left home alone." At 7:05am, Facility Staff (FS) #2 indicated client B was an accurate reporter of information. At 7:10am, FS #4 indicated client B was an accurate reporter of information.</p>	W0154	<p>W 154 Staff Treatment of Clients The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>1. What corrective action will be accomplished? · Staff will be retrained on Occazio's policy #2105 Abuse, Neglect and Exploitation at their staff meeting on 11-27-12. · Staff will retrained on the incident reporting guidelines and the investigation process. · The importance of following the investigation process was reviewed with the RC and ARC on 11-19-12. · All staff members who fail to notify the administrator immediately will face disciplinary action per Occazio's policy regarding abuse, neglect and exploitation. 2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents have the potential to be affected by the same deficient practice. · Staff will be retrained on Occazio's policy #2105 Abuse, Neglect and Exploitation at their staff meeting on 11-27-12. · Staff will retrained on the incident reporting guidelines and the investigation process. · The importance of</p>	12/02/2012			

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	<p>Confidential Interview #1 (CI #1) indicated client B was an accurate reporter of information. CI #1 stated client B "was left home alone on 8/10/12 when he was ill." CI #1 stated client B was in bed asleep on the morning of 8/10/12, the staff left in the van with the other clients for transport to the workshop, and a staff found client B "in bed later in the afternoon" after the staff returned to the group home. CI #1 stated the clients leave for workshop at "around 7:30am" daily.</p> <p>Confidential Interview #2 (CI #2) stated client B was "left home alone a few hours" on 8/10/12 and the incident was not investigated.</p> <p>On 10/31/12 at 10:20am, the facility's Workshop Attendance Record for client B was reviewed and indicated client B did not attend workshop on 8/10/12.</p> <p>On 10/30/12 at 11:20am, an interview with the Area Director (AD) was conducted. The AD stated client B's incident on 8/10/12 was "not reported (to BDDS) because [client B] could be left home alone for a short period of time at [client B's] mothers home." The AD stated the incident on 8/10/12 "was not planned to leave [client B] home alone (and) we have not determined how long</p>		<p>following the investigation process was reviewed with the RC and ARC on 11-19-12. · All staff members who fail to notify the administrator immediately will face disciplinary action per Occazio's policy regarding abuse, neglect and exploitation. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: · Staff will be retrained on Occazio's policy #2105 Abuse, Neglect and Exploitation at their staff meeting on 11-27-12. · Staff will retrained on the incident reporting guidelines and the investigation process. · The importance of following the investigation process was reviewed with the RC and ARC on 11-19-12. · All staff members who fail to notify the administrator immediately will face disciplinary action per Occazio's policy regarding abuse, neglect and exploitation. 4. How will the corrective action be monitored to ensure the deficient practice will not recur? · The RC will monitor on a daily basis when they are in the home. · The Program Specialist will monitor as they complete their audits.</p>		

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	<p>[client B] was at home alone." When asked if staff failed to supervise client B and know his whereabouts, the AD stated "We should always know where our clients are and we did not supervise him (on 8/10/12)." The AD stated "no one knew" client B was at home alone on 8/10/12. The AD indicated no investigation was completed for the allegation of neglect for client B's 8/10/12 incident of being left home alone.</p> <p>This federal tag relates to complaint #IN00117915.</p> <p>9-3-2(a)</p>				