

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G567		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/25/2013	
NAME OF PROVIDER OR SUPPLIER  OCCAZIO INC				STREET ADDRESS, CITY, STATE, ZIP CODE 11 GLORIA DR TRAFALGAR, IN 46181			
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W000000	<p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>Dates of Survey: 6/17/13, 6/18/13, 6/20/13 and 6/25/13.</p> <p>Facility Number: 001081 Provider Number: 15G567 AIMS Number: 100239920</p> <p>Surveyor: Keith Briner, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed July 1, 2013 by Dotty Walton, QIDP.</p>	W000000					

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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W000104	<p><b>483.410(a)(1) GOVERNING BODY</b> The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview for 1 of 4 sampled clients (#2), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility van's wheelchair safety mechanisms were maintained.</p> <p>Findings include:</p> <p>The facilities BDDSRs (Bureau of Developmental Disabilities Services Reports) and investigations were reviewed on 6/17/13 at 12:36 PM. The review indicated the following:</p> <p>-BDDSR dated 4/19/13 indicated on 4/18/13 while facility staff transported client #2 from her day service provider to the group home, client #2's wheelchair tipped over. Client #2 was taken to the emergency room of a local hospital where client #2 was treated for a head injury. Client #2 received 5 staples to close her head injury.</p> <p>-Investigation dated 4/19/13 regarding the 4/18/13 BDDSR indicated, "[Client #2's] wheelchair tipped over when driver [SM #1(Site Manager)] went around a sharp</p>	W000104	<p><b>W104 Governing Body</b> The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility van's wheelchair safety mechanisms were maintained.</p> <p><b>1.What corrective action will be accomplished?</b></p> <ul style="list-style-type: none"> <li>· Develop and implement protocol regarding reporting of maintenance issues by direct support staff.</li> <li>· Training with support staff and site manager regarding protocol for reporting maintenance issues.</li> </ul> <p><b>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p>	07/25/2013			

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	<p>turn on [highway]. [Client #2] was injured from the fall and received 5 staples. [SM #1] discovered that [client #2's] seatbelt was not buckled around her at the time of the incident. [SM #1] observed that three tie downs were around the wheelchair but the back right tie down was not around the wheelchair. Staff who secured the wheelchair was [staff #1]. Interview indicated [staff #1] had secured all 4 tie downs but that he had to make sure that they locked in because they did not do so automatically as they should. [Staff #1] also stated that sometimes in route the tie downs tend to loosen up. [Staff #1] also reported that he did not put [client #2's] seatbelt on because it had not been working properly for some time and the seatbelt would not go on. [Staff #1] indicated the previous RC (Residential Coordinator) was aware of this." The 4/19/13 investigation indicated, "[SM #1] said that the bus had been at [dealership] the previous day (4/17/13) and the seatbelt issue was to be addressed. [SM #1] said that the seatbelt would go around [client #2] but that it had to be manipulated to do so."</p> <p>AS #1 (Administrative Staff) was interviewed on 6/17/13 at 2:50 PM. AS #1 indicated she had completed the 4/19/13 investigation regarding client #2's 4/18/13 van injury. AS #1 indicated the</p>		<ul style="list-style-type: none"> <li>· All clients have the potential to be affected by this deficient practice.</li> <li>· Develop and implement protocol regarding reporting of maintenance issues by direct support staff.</li> <li>· Training with support staff and site manager regarding protocol for reporting maintenance issues.</li> </ul> <p><b>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>· Training with support staff and site manager regarding protocol for reporting maintenance issues.</li> <li>· Develop and implement protocol regarding reporting of maintenance issues by direct support staff.</li> </ul> <p><b>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</b></p>		

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	<p>previous RC had worked for the facility through September 25, 2012. AS #1 indicated the previous RC had not notified her regarding the wheelchair tie downs and/or the wheelchair seat belt. AS #1 indicated during her investigation staff #1 reported he had notified the previous RC prior to 9/25/12 regarding the wheelchair tie downs and/or seat belt not working correctly.</p> <p>AS #1 indicated she had assisted with transporting client #2 using the facility van prior to the 4/18/13 incident. When asked if she had noticed any issues with the wheelchair tie downs or seat belt when she assisted, AS #1 stated, "...noticed that it (seatbelt) was tight. I noticed that I had to hit the button to fasten the seatbelt but I wasn't aware that it should have fastened differently." When asked when she had assisted client #2 with transport, AS #1 stated, "a few times... the seat belt would be tight every once in a while. I can't remember when I assisted for sure. Probably a few times over about a month." When asked how the facility administration should have addressed client #2's wheelchair tie downs and/or seat belt, AS #1 stated, "at that point it would have been a safety issue. We would have gotten it in to be repaired and the clients wouldn't have been using it."</p>		<ul style="list-style-type: none"> <li>· The RC will monitor when they are in the home.</li> <li>· The ARC will monitor as they complete their audits.</li> <li>· The SM will monitor daily as they are in the home.</li> <li>· The Maintenance Director will monitor as he is in the home.</li> </ul> <p><b>1.What is the date by which the systemic changes will be completed?</b></p> <p>July 25, 2013</p>				

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	<p>Staff #2 was interviewed on 6/18/13 at 6:52 AM. Staff #2 stated, "The wheelchair straps were not working for a long time. That's why the van is back in the shop now. They take it to the shop and I don't know what they do. It seems to come back still not working."</p> <p>9-3-1(a)</p>				

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W000149	<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. Based on record review and interview for 1 of 9 allegations of abuse, neglect, mistreatment, exploitation and/or injuries of unknown origin reviewed, the facility failed to implement its policy and procedures to prevent injury to client #2 while using the facility van for transportation. The facility failed to implement its policy and procedures to conduct a thorough investigation regarding the facility van's wheelchair safety tie downs and seatbelt. The facility failed to implement its policy and procedure to develop and implement corrective measures to ensure facility staff reported van safety issues.</p> <p>Findings include:</p> <p>The facilities BDDSRs (Bureau of Developmental Disabilities Services Reports) and investigations were reviewed on 6/17/13 at 12:36 PM. The review indicated the following:</p> <p>-BDDSR dated 4/19/13 indicated on 4/18/13 while facility staff transported client #2 from her day service provider to the group home, client #2's wheelchair tipped over. Client #2 was taken to the</p>	W000149	<p><b>W149 Staff Treatment of Clients</b></p> <p>The facility failed to implement its policy and procedures to conduct a thorough investigation regarding the facility van's wheelchair safety tie-downs and seatbelt. The facility failed to implement its policy and procedure to develop and implement corrective measures to ensure facility staff reported van safety issues.</p> <p><b>1.What corrective action will be accomplished?</b></p> <ul style="list-style-type: none"> <li>· A member of the HR department will participate in investigations involving staff to ensure thoroughness of investigation and to ensure there is no conflict of interest by investigative team.</li> <li>· Develop and implement protocol regarding reporting of maintenance issues by direct support staff.</li> <li>· Training with Area</li> </ul>	07/25/2013			

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	<p>emergency room of a local hospital where client #2 was treated for a head injury. Client #2 received 5 staples in her head as a result of her wheelchair tipping over during the van transport.</p> <p>-Investigation dated 4/19/13 regarding the 4/18/13 BDDSR indicated, "[Client #2's] wheelchair tipped over when driver [SM #1 (Site Manager)] went around a sharp turn on [highway]. [Client #2] was injured from the fall and received 5 staples. [SM #1] discovered that [client #2's] seatbelt was not buckled around her at the time of the incident. [SM #1] observed that three ties downs were around the wheelchair but the back right tie down was not around the wheelchair. Staff who secured the wheelchair was [staff #1]. Interview indicated [staff #1] had secured all 4 tie downs but that he had to make sure that they locked in because they did not do so automatically as they should. [Staff #1] also stated that sometimes in (sic) route the tie downs tend to loosen up. [Staff #1] also reported that he did not put [client #2's] seatbelt on because it had not been working properly for some time and the seatbelt would not go on. [Staff #1] indicated the previous RC (Residential Coordinator) was aware of this." The 4/19/13 investigation indicated, "[SM #1] said that the bus had been at [dealership] the previous day</p>		<p>Residential Coordinator and Residential Coordinator regarding investigation process.</p> <ul style="list-style-type: none"> <li>· Training with support staff and site manager regarding protocol for reporting maintenance issues.</li> <li>· Area Residential Coordinator will consult with Program Specialist prior to investigation to ensure no conflict of interest occurs in investigative team.</li> </ul> <p><b>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>· All clients have the potential to be affected by this deficient practice.</li> <li>· A member of the HR department will participate in investigations involving staff to ensure thoroughness of investigation and to ensure there is no conflict of interest by investigative team.</li> <li>· Develop and implement protocol regarding reporting of maintenance issues by direct support staff.</li> </ul>				

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	<p>(4/17/13) and the seatbelt issue was to be addressed. [SM #1] said that the seatbelt would go around [client #2] but that it had to be manipulated to do so." The 4/19/13 investigation did not indicate the facility had determined if SM #1 had knowledge of client #2's wheelchair tie downs and/or seatbelt not functioning properly prior to the 4/18/13 incident. The 4/19/13 investigation did not indicate the facility had determined if SM #1 had reported maintenance issues to the facility administrator or maintenance for repair. The 4/19/13 investigation did not indicate the facility had determined if AS (Administrative Staff) #1 had knowledge of client #2's wheelchair tie downs and/or seatbelt not functioning properly. The 4/19/13 investigation did not indicate the facility had reviewed maintenance logs or other electronic communication logs to determine if facility staff had reported client #2's wheelchair tie downs or if the seatbelt had not been operating properly.</p> <p>AS #1 was interviewed on 6/17/13 at 2:50 PM. AS #1 indicated she had completed the 4/19/13 investigation regarding client #2's 4/18/13 van injury. AS #1 indicated the previous RC had worked for the facility through September 25, 2012. AS #1 indicated the previous RC had not notified her regarding the wheelchair tie downs and/or the wheelchair seatbelt. AS</p>		<ul style="list-style-type: none"> <li>· Training with Area Residential Coordinator and Residential Coordinator regarding investigation process.</li> <li>· Training with support staff and site manager regarding protocol for reporting maintenance issues.</li> <li>· Area Residential Coordinator will consult with Program Specialist prior to investigation to ensure no conflict of interest occurs in investigative team.</li> </ul> <p><b>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>· Training with Area Residential Coordinator and Residential Coordinator regarding investigation process.</li> <li>· Training with support staff and site manager regarding protocol for reporting maintenance issues.</li> <li>· A member of the HR department will participate in investigations involving staff to ensure thoroughness of</li> </ul>				

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	<p>#1 indicated during her investigation staff #1 reported he had notified the previous RC prior to 9/25/12 regarding the wheelchair tie downs and seatbelt not working correctly.</p> <p>AS #1 indicated she had assisted with transporting client #2 using the facility van prior to the 4/18/13 incident. When asked if she had observed any issues with the wheelchair tie downs or seat belt when she assisted, AS #1 stated, "...noticed that it (seatbelt) was tight. I noticed that I had to hit the button to fasten the seatbelt but I wasn't aware that it should have fastened differently." When asked when she had assisted client #2 with transport, AS #1 stated, "a few times... the seat belt would be tight every once in a while. I can't remember when I assisted for sure. Probably a few times over about a month." When asked how the facility administration should have addressed client #2's wheelchair tie downs and/or seat belt, AS #1 stated, "at that point it would have been a safety issue. We would have gotten it in to be repaired and the clients wouldn't have been using it." When asked who should conduct an investigation of an allegation or situation that AS #1 was directly or indirectly involved in, AS #1 stated, "In those incidents my supervisor would conduct the investigation." When asked if AS #1 had interviewed the driver of the van, SM</p>		<p>investigation and to ensure there is no conflict of interest by investigative team.</p> <ul style="list-style-type: none"> <li>· Develop and implement protocol regarding reporting of maintenance issues by direct support staff.</li> <li>· Area Residential Coordinator will consult with Program Specialist prior to investigation to ensure no conflict of interest occurs in investigative team.</li> </ul> <p><b>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</b></p> <ul style="list-style-type: none"> <li>· The RC will monitor when they are in the home.</li> <li>· The ARC will monitor as they complete their audits.</li> <li>· The SM will monitor daily as they are in the home.</li> <li>· The Maintenance Director will monitor as he is in the home.</li> </ul> <p><b>1.What is the date by which the systemic changes will be completed?</b></p>				

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	<p>#1, to determine if she had previously been made aware of or experienced client #2's wheelchair tie downs/seatbelt not functioning properly, AS #1 stated, "No." When asked if facility staff had been retrained regarding reporting facility van maintenance issues, AS #1 stated, "No, we didn't in-service them on that." AS #1 indicated the facility abuse and neglect policy should be implemented.</p> <p>Staff #2 was interviewed on 6/18/13 at 6:52 AM. Staff #2 stated, "The wheelchair straps were not working for a long time. That's why the van is back in the shop now. They take it to the shop and I don't know what they do. It seems to come back still not working."</p> <p>The facilities policy and procedure entitled, "Suspected Abuse, Neglect and Exploitation Reporting" dated 1/1/11 indicated, "Occazio, Incorporated will not tolerate mistreatment, abuse, neglect or exploitation of any Occazio resident/consumer. Employees who witness any form of abuse, neglect or exploitation or have a reason to believe that abuse, neglect or exploitation has occurred (see definitions below) must report the incident(s) to their immediate supervisor and observe the procedures outlined below." The 1/1/11 Suspected Abuse, Neglect and Exploitation</p>		July 25, 2013				

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	Reporting policy indicated, "For the group home program: Upon receipt of the written abuse report, the Area Residential Coordinator (ARC) or his/her designee will promptly convene the suspected Abuse, Neglect, or Exploitation Committee and conduct a full investigation to determine whether, based on a preponderance of evidence, there is reason to believe abuse, neglect and/or exploitation occurred and whether the findings warrant any employee(s) discipline. The ARC will interview the suspected perpetrator(s), the suspected injured party(ies), and any witnesses. The RC (Residential Coordinator) and/or the third member of the Suspected Abuse, Neglect or Exploitation Committee may assist with interviews as requested by the ARC." The 1/1/11 Suspected Abuse, Neglect and Exploitation Reporting policy indicated, "Neglect- 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...." The 1/1/11 Suspected Abuse, Neglect and Exploitation Reporting policy indicated, "if the Committee finds that any employee(s) abuse, neglected and/or exploited a resident/consumer, Occazio will take appropriate disciplinary action,						

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	<p>up to and including discharge, and may seek criminal prosecution. The Committee will cooperate with APS (Adult Protective Services) or any other designated entity to obtain any necessary protective services for the resident/consumer, including the development of a plan in cooperation with the resident/consumer, whereby the least restrictive protective services necessary to protect the resident/consumer will be made available to the resident/consumer. The Committee also will cooperate with APS or any other designated entity to monitor the protective services to determine their effectiveness. The 1/1/11 Suspected Abuse, Neglect and Exploitation Reporting policy indicated, "Accident- harm caused to a resident/consumer that is not attributable to abuse, neglect or exploitation; where evidence indicates that an event is merely an unintended happening or something that happened by chance. (In an investigation, those circumstances leading up to an accident should be reviewed to determine if neglect may have occurred precedent to the accident)."</p> <p>9-3-2(a)</p>				

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W000154	<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 9 allegations of abuse, neglect, mistreatment, exploitation and/or injuries of unknown origin reviewed, the facility failed to conduct a thorough investigation regarding the facility van's wheelchair safety tie downs and seatbelt regarding client #2.</p> <p>Findings include:</p> <p>The facilities BDDSRs (Bureau of Developmental Disabilities Services Reports) and investigations were reviewed on 6/17/13 at 12:36 PM. The review indicated the following:</p> <p>-BDDSR dated 4/19/13 indicated on 4/18/13 while facility staff transported client #2 from her day service provider to the group home client #2's wheelchair tipped over. Client #2 was taken to the emergency room of a local hospital where client #2 was treated for a head injury. Client #2 received 5 staples in her head as a result of her wheelchair tipping over during the van transport.</p> <p>-Investigation dated 4/19/13 regarding the 4/18/13 BDDSR indicated, "[Client #2's]</p>	W000154	<p><b>W154 Staff Treatment of Clients</b></p> <p>The facility failed to conduct a thorough investigation regarding the facility van's wheelchair safety tie-downs and seatbelt regarding Client #2.</p> <p><b>1.What corrective action will be accomplished?</b></p> <ul style="list-style-type: none"> <li>· A member of the HR department will participate in investigations involving staff to ensure thoroughness of investigation and to ensure there is no conflict of interest by investigative team.</li> <li>· Training with Area Residential Coordinator and Residential Coordinator regarding investigation process.</li> <li>· Area Residential Coordinator will consult with Program Specialist prior to investigation to ensure no conflict of interest occurs in investigative team.</li> </ul>	07/25/2013			

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	wheelchair tipped over when driver [SM #1 (Site Manager)] went around a sharp turn on [highway]. [Client #2] was injured from the fall and received 5 staples. [SM #1] discovered that [client #2's] seatbelt was not buckled around her at the time of the incident. [SM #1] observed that three ties downs were around the wheelchair but the back right tie down was not around the wheelchair. Staff who secured the wheelchair was [staff #1]. Interview indicated [staff #1] had secured all 4 tie downs but that he had to make sure that they locked in because they did not do so automatically as they should. [Staff #1] also stated that sometimes in (sic) route the tie downs tend to loosen up. [Staff #1] also reported that he did not put [client #2's] seatbelt on because it had not been working properly for some time and the seatbelt would not go on. [Staff #1] indicated the previous RC (Residential Coordinator) was aware of this." The 4/19/13 investigation indicated, "[SM #1] said that the bus had been at [dealership] the previous day (4/17/13) and the seatbelt issue was to be addressed. [SM #1] said that the seatbelt would go around [client #2] but that it had to be manipulated to do so." The 4/19/13 investigation did not indicate the facility had determined if SM #1 had knowledge of client #2's wheelchair tie downs and/or seatbelt not functioning properly prior to		<p><b>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>· All clients have the potential to be affected by this deficient practice.</li> <li>· A member of the HR department will participate in investigations involving staff to ensure thoroughness of investigation and to ensure there is no conflict of interest by investigative team.</li> <li>· Training with Area Residential Coordinator and Residential Coordinator regarding investigation process.</li> <li>· Area Residential Coordinator will consult with Program Specialist prior to investigation to ensure no conflict of interest occurs in investigative team.</li> </ul> <p><b>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p>				

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	<p>the 4/18/13 incident. The 4/19/13 investigation did not indicate the facility had determined if SM #1 had reported maintenance issues to the facility administrator or maintenance for repair. The 4/19/13 investigation did not indicate the facility had determined if AS (Administrative Staff) #1 had knowledge of client #2's wheelchair tie downs and/or seatbelt not functioning properly. The 4/19/13 investigation did not indicate the facility had reviewed maintenance logs or other electronic communication logs to determine if facility staff had reported client #2's wheelchair tie downs or seatbelt had not been operating properly.</p> <p>AS #1 was interviewed on 6/17/13 at 2:50 PM. AS #1 indicated she had completed the 4/19/13 investigation regarding client #2's 4/18/13 van injury. AS #1 indicated the previous RC had worked for the facility through September 25, 2012. AS #1 indicated the previous RC had not notified her regarding the wheelchair tie downs and/or the wheelchair seatbelt. AS #1 indicated during her investigation staff #1 reported he had notified the previous RC prior to 9/25/12 regarding the wheelchair tie downs and seatbelt not working correctly.</p> <p>AS #1 indicated she had assisted with transporting client #2 using the facility van prior to the 4/18/13 incident. When</p>		<ul style="list-style-type: none"> <li>· A member of the HR department will participate in investigations involving staff to ensure thoroughness of investigation and to ensure there is no conflict of interest by investigative team.</li> <li>· Training with Area Residential Coordinator and Residential Coordinator regarding investigation process.</li> <li>· Area Residential Coordinator will consult with Program Specialist prior to investigation to ensure no conflict of interest occurs in investigative team.</li> </ul> <p><b>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</b></p> <ul style="list-style-type: none"> <li>· The RC will monitor when they are in the home.</li> <li>· The ARC will monitor as they complete their audits.</li> <li>· The SM will monitor daily as they are in the home.</li> <li>· The Program Specialist will monitor as they complete their audits.</li> </ul>				

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	<p>asked if she had observed any issues with the wheelchair tie downs or seat belt when she assist, AS #1 stated, "...noticed that it (seatbelt) was tight. I noticed that I had to hit the button to fasten the seatbelt but I wasn't aware that it should have fastened differently." When asked when she had assisted client #2 with transport, AS #1 stated, "a few times... the seat belt would be tight every once in a while. I can't remember when I assisted for sure. Probably a few times over about a month." When asked who should conduct an investigation of an allegation or situation that AS #1 was directly or indirectly involved in, AS #1 stated, "In those incidents my supervisor would conduct the investigation." When asked if AS #1 had interviewed the driver of the van, SM #1, to determine if she had previously been made aware of or experienced client #2's wheelchair tie downs/seatbelt not functioning properly, AS #1 stated, "No."</p> <p>9-3-2(a)</p>		<p><b>1.What is the date by which the systemic changes will be completed?</b></p> <p>July 25, 2013</p>		

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W000157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 1 of 9 allegations of abuse, neglect, mistreatment, exploitation and/or injuries of unknown origin reviewed, the facility failed to develop and implement corrective measures The facility failed to implement its policy and procedure to develop and implement corrective measures to ensure facility staff report van safety issues.</p> <p>Findings include:</p> <p>The facilities BDDSRs (Bureau of Developmental Disabilities Services Reports) and investigations were reviewed on 6/17/13 at 12:36 PM. The review indicated the following:</p> <p>-BDDSR dated 4/19/13 indicated on 4/18/13 while facility staff transported client #2 from her day service provider to the group home client #2's wheelchair tipped over. Client #2 was taken to the emergency room of a local hospital where client #2 was treated for a head injury. Client #2 received 5 staples in her head as a result of her wheelchair tipping over during the van transport.</p> <p>-Investigation dated 4/19/13 regarding the</p>	W000157	<p><b>W157 Staff Treatment of Clients</b></p> <p>The facility failed to implement its policy and procedure to develop and implement corrective measures to ensure facility staff report van safety issues.</p> <p><b>1.What corrective action will be accomplished?</b></p> <ul style="list-style-type: none"> <li>· Develop and implement protocol regarding reporting of maintenance issues by direct support staff.</li> <li>· Training with support staff and site manager regarding protocol for reporting maintenance issues.</li> </ul> <p><b>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>· All clients have the potential to be affected by this deficient practice.</li> </ul>	07/25/2013			

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	4/18/13 BDDSR indicated, "[Client #2's] wheelchair tipped over when driver [SM #1 (Site Manager)] went around a sharp turn on [highway]. [Client #2] was injured from the fall and received 5 staples." [SM #1] discovered that [client #2's] seatbelt was not buckled around her at the time of the incident. [SM #1] observed that three ties downs were around the wheelchair but the back right tie down was not around the wheelchair. Staff who secured the wheelchair was [staff #1]. Interview indicated [staff #1] had secured all 4 tie downs but that he had to make sure that they locked in because they did not do so automatically as they should. [Staff #1] also stated that sometimes in (sic) route the tie downs tend to loosen up. [Staff #1] also reported that he did not put [client #2's] seatbelt on because it had not been working properly for some time and the seatbelt would not go on. [Staff #1] indicated the previous RC (Residential Coordinator) was aware of this." [SM #1] said that the seatbelt would go around [client #2] but that it had to be manipulated to do so." The 4/19/13 investigation resolution indicated, "Tie downs will be replaced on the bus. Those tie downs will not be utilized until they are replaced. Site manager will consult with [dealership] again regarding the seatbelt. All staff at the group home will receive a refresher training regarding		<ul style="list-style-type: none"> <li>· Develop and implement protocol regarding reporting of maintenance issues by direct support staff.</li> <li>· Training with support staff and site manager regarding protocol for reporting maintenance issues.</li> </ul> <p><b>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>· Training with support staff and site manager regarding protocol for reporting maintenance issues.</li> <li>· Develop and implement protocol regarding reporting of maintenance issues by direct support staff.</li> </ul> <p><b>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</b></p> <ul style="list-style-type: none"> <li>· The RC will monitor when they are in the home.</li> </ul>				

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	<p>vehicle safety and securing the wheelchair on the bus." The 4/19/13 investigation did not indicate how the facility would ensure facility staff reported/communicated vehicle operation issues related to wheelchair safety tie downs and/or seatbelts. The 4/19/13 investigation did not indicate how the facility would provide oversight to ensure the facility van's wheelchair tie downs and/or seatbelts were maintained in a safe manner to prevent further injury to client #2.</p> <p>AS #1 was interviewed on 6/17/13 at 2:50 PM. AS #1 indicated she had completed the 4/19/13 investigation regarding client #2's 4/18/13 van injury. AS #1 indicated the previous RC had worked for the facility through September 25, 2012. AS #1 indicated the previous RC had not notified her regarding the wheelchair tie downs and/or the wheelchair seatbelt. AS #1 indicated during her investigation staff #1 reported he had notified the previous RC prior to 9/25/12 regarding the wheelchair tie downs and seatbelt not working correctly. AS #1 indicated staff #1 had not notified her of concerns regarding client #2's wheelchair tie downs or seatbelt. When asked if facility staff had been retrained regarding reporting facility van maintenance issues, AS #1 stated, "No, we didn't in-service them on</p>		<ul style="list-style-type: none"> <li>· The ARC will monitor as they complete their audits.</li> <li>· The SM will monitor daily as they are in the home.</li> <li>· The Maintenance Director will monitor as he is in the home.</li> </ul> <p><b>1.What is the date by which the systemic changes will be completed?</b></p> <p>July 25, 2013</p>				

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	<p>that."</p> <p>Staff #2 was interviewed on 6/18/13 at 6:52 AM. Staff #2 stated, "The wheelchair straps were not working for a long time. That's why the van is back in the shop now. They take it to the shop and I don't know what they do. It seems to come back still not working."</p> <p>9-3-2(a)</p>			

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W000356	<p>483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.</p> <p>Based on record review and interview for 2 of 4 sampled clients (#1 and #2), the facility failed to ensure clients #1 and #2 received timely recommended dental treatment.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 6/18/13 at 8:25 AM. Client #1's dental visit form dated 5/21/12 indicated, "Recommendations: return in 6 months for cleaning." Client #1's record did not indicate documentation of additional dental cleanings or follow up dental services.</p> <p>2. Client #2's record was reviewed on 6/18/13 at 9:54 AM. Client #2's record did not indicate documentation of client #2 receiving dental services.</p> <p>Interview with the facility nurse on 6/18/13 at 10:15 AM indicated documentation of additional dental services for client #1 could not be located.</p> <p>Interview with RC #1 (Residential</p>	W000356	<p><b>W356 Comprehensive Dental Treatment</b></p> <p>The facility failed to ensure Clients #1 and #2 received timely recommended dental treatment.</p> <p><b>1.What corrective action will be accomplished?</b></p> <ul style="list-style-type: none"> <li>· Client #1 dental appointment scheduled for 11/4/2013 (earliest available appointment). Site Manager will be notified by dental office of any cancellations, and Client #1 will be taken if earlier date is available.</li> <li>· Client #2 dental appointment scheduled for 7/11/2013.</li> </ul> <p><b>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p>	07/25/2013			

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	Coordinator) on 6/18/13 at 11:18 AM indicated client #2 had been to the dentist in October 2011 with recommendations for yearly revisits.  9-3-6(a)		<ul style="list-style-type: none"> <li>· All residents have the potential to be affected by the same deficient practice.</li> <li>· All client's dental appointments will be reviewed to ensure that they are done in a timely manner.</li> <li>· Site Manager will be provide with a tracking form to ensure that appointments are done in a timely manner.</li> <li>· Nurse will review charts quarterly to ensure recommendations from physicians have been completed.</li> <li>· QMRP will monitor appointment notes weekly to ensure recommendations have been completed.</li> </ul> <p style="text-align: center;"><b>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>· Site manager will be provided with a tracking form to ensure that appointments are done in a timely manner.</li> <li>· All client's dental appointments will be reviewed to</li> </ul>		

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			<p>ensure that they are done in a timely manner.</p> <ul style="list-style-type: none"> <li>· Nurse will review charts quarterly to ensure recommendations from physicians have been completed.</li> <li>· QMRP will monitor appointment notes weekly to ensure recommendations have been completed.</li> </ul> <p><b>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</b></p> <ul style="list-style-type: none"> <li>· The RC will monitor when they are in the home.</li> <li>· The ARC will monitor as they complete their audits.</li> <li>· The SM will monitor daily as they are in the home.</li> <li>· The Nurse will monitor as they complete their audits.</li> </ul> <p><b>1.What is the date by which the systemic changes will be completed?</b></p>		

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W000440	<p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) plus 3 additional clients (#5, #6 and #7), the facility failed to conduct evacuation drills for each quarter on each shift of personnel.</p> <p>Findings include:</p> <p>The facility's evacuation drill records were reviewed on 6/17/13 at 3:40 PM. The review indicated the facility failed to conduct an evacuation drill for 7 of 7 clients (#1, #2, #3, #4, #5, #6 and #7) for the first quarter, January through March 2013 for the 12:00 AM through 4:00 AM shift. The review indicated the facility failed to conduct an evacuation drill for the third quarter, July through September 2012 for the 12:00 AM through 4:00 AM shift. The review indicated the facility failed to conduct an evacuation drill for the fourth quarter, October through December 2012 for the 4:00 PM through 12:00 AM shift.</p> <p>AS #1 (Administrative Staff) was interviewed on 6/18/13 at 12:45 PM. AS #1 indicated there were no additional evacuation drills.</p>	W000440	<p><b>W440 Evacuation Drills</b></p> <p>The facility failed to conduct an evacuation drill for the fourth quarter, October through December 2013 for the 4pm through 12am shift.</p> <p><b>1.What corrective action will be accomplished?</b></p> <ul style="list-style-type: none"> <li>· SMs will be trained on regulations regarding evacuation drills.</li> <li>· Site Manager provided with a tracking form to ensure drills are done in accordance to federal guidelines.</li> <li>· Area Residential Coordinator and Residential Coordinator will review drills monthly to ensure drills are being properly run.</li> </ul> <p><b>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p>	07/25/2013			

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	9-3-7(a)		<ul style="list-style-type: none"> <li>· All clients have the potential to be affected by this deficient practice.</li> <li>· SMs will be trained on regulations regarding evacuation drills.</li> <li>· Site Manager provided with a tracking form to ensure drills are done in accordance to federal guidelines.</li> <li>· Area Residential Coordinator and Residential Coordinator will review drills monthly to ensure drills are being properly run.</li> </ul> <p><b>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>· Site Manager provided with a tracking form to ensure drills are done in accordance to federal guidelines.</li> <li>· SMs will be trained on regulations regarding evacuation drills.</li> <li>· Area Residential Coordinator and Residential Coordinator will review drills</li> </ul>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G567	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/25/2013
NAME OF PROVIDER OR SUPPLIER  OCCAZIO INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11 GLORIA DR TRAFALGAR, IN 46181		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
			<p>monthly to ensure drills are being properly run.</p> <p><b>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</b></p> <ul style="list-style-type: none"> <li>· The RC will monitor when they are in the home.</li> <li>· The ARC will monitor as they complete their audits.</li> <li>· The SM will monitor daily as they are in the home.</li> </ul> <p><b>1.What is the date by which the systemic changes will be completed?</b></p> <p>July 25, 2013</p>		