

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 12/12/2014
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NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11 GLORIA DR TRAFALGAR, IN 46181
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W000000	<p>This visit was for the investigation of complaint #IN00158079.</p> <p>Complaint #IN00158079 - Substantiated, Federal/state deficiencies related to the allegation are cited at W149 and W153.</p> <p>This visit was in conjunction with the Post Certification Revisit (PCR) to the recertification and state licensure survey completed on 9/15/14.</p> <p>Survey Dates: December 11 and 12, 2014</p> <p>Facility Number: 001081 Provider Number: 15G567 AIM Number: 100239920</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/19/14 by Ruth Shackelford, QIDP.</p>	W000000		
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.</p>			

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

TITLE

(X6) DATE

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

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	<p>Based on record review and interview for 1 of 11 incident/investigative reports reviewed affecting client E, the facility failed to implement its policies and procedures to submit an incident report to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner.</p> <p>Findings include:</p> <p>On 12/11/14 at 3:00 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 10/13/14 at 4:00 PM (reported to BDDS on 10/15/14), staff #3 counted client E's controlled medication, Hydrocodone. Staff #3 found the count was off by 3 pills. Staff #3 reported the issue to the Home Manager (HM). The HM and Area Director (AD) went to the home to count the pills and confirmed the pills were missing. It appeared the pills were all accounted for at the 7:00 AM medication pass on 10/13/14. All staff who were potentially in the house alone on 10/13/14 between 7:00 AM and 4:00 PM were suspended pending the outcome of the investigation. The HM, staff #3 and staff #5 were suspended. On 10/14/14 the AD was again at the home inspecting the medication packaging. At that time, the AD discovered a total of 25 Hydrocodone pills had been removed from the package and had been replaced</p>	W000149	<p>1.What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · Training with Program Director regarding reporting incidents in a timely manner. <p>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All clients have the potential to be affected by this practice.</p> <p>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · Area Director will record reportable events on incident tracking form upon notification of events. · Program Director will submit report via Incident Reporting System and email to all applicable parties (including the Area Director) within 24 hours of incident. · Area Director will monitor all reportable events within a 24-hour period to ensure incidents have been reported. <p>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · Area Director and QA Specialist will monitor report monthly to ensure compliance with 	01/11/2015

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	<p>with a similar looking pill (Tylenol). The AD notified the police and a report was filed. The medication packaging was removed from the home by the police and will be used as part of the police investigation.</p> <p>The follow-up BDDS report, dated 10/28/14, indicated, "All staff were investigated, and the investigation was completed regarding the missing controlled substance (Hydrocodone) of [client E]. The evidence from the investigation supported that 25 pills were missing out of the bubble card and had been replaced with Acetaminophen. The evidence did not support specific staff involvement with the missing medication. Evidence supported that proper counting procedures were followed in regard to the controlled substance. During the investigation it was discovered that the dining room windows did not properly lock. It could not be determined if the medication was taken for financial gain; however, the police were notified regarding the missing medication and are currently investigating the incident.</p> <p>All staff have been retrained regarding the controlled count protocol as well as have been trained to check pills to ensure that correct pills are in the package. The</p>		<p>timeliness.</p> <p>1.What is the date by which the systemic changes will be completed?</p> <p>January 11, 2014</p>	

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	<p>windows in the dining room have been repaired to ensure locking. Staff are also to document at the end of shift that all windows are locked and secured, and to check that all windows are locked and secured upon leaving home. The doors on the house automatically lock upon exit. A new order had to be obtained for [client E's] Hydrocodone. The order was received and the medication will be in the house 10/29/14.</p> <p>1. All staff retrained on controlled medication count.</p> <p>2. Protocol updated to include that staff check the actual medication to ensure that it is the correct medication. Staff also trained to notify supervisor immediately if it appears that the packaging has been tampered with.</p> <p>3. Windows have been repaired to ensure that they can be locked.</p> <p>4. Staff to check windows at end of shift and when leaving the home to ensure that all windows are locked and secured. Staff to document that all windows are secured. Doors automatically lock upon exit."</p> <p>The investigation, dated 10/17/14, indicated, in part, "[Client E] also has a diagnosis of compression deformities of thoracic spine, and at times he can have extreme back pain. He chooses not to</p>				

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	<p>communicate verbally, although he can. When [client E] is having severe back pain, he will communicate this by refusing to get out of bed. When he does attempt to walk, he will hold his back. At this time, he will be offered is (sic) PRN (as needed) Hydrocodone so it must be present in the house at all times. Typically, bed rest and administration of the PRN Hydrocodone has (sic) been effective treatment for his back pain."</p> <p>The investigation's interview with the Area Director (AD) indicated, in part, "States [HM] then showed her where the Hydrocodone bubble card had been taped on the back and she said it was not like that when she counted the meds that morning. [HM] stated to her that there had been a piece of tape over on pill back that had been punctured, but she did not understand why someone had taped the whole card. States on Tuesday 10/14/14 she was talking with [name of nurse] about the missing controlled meds, and informed her about the tape on the back of the bubble card. States [name of nurse] asked if she [AD] was sure there was Hydrocodone in the package (referring to another incident in one of the homes years ago where someone had punched out the controlled med and replaced with other pills). Stated she told [nurse] she was pretty sure it was</p>			

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	<p>Hydrocodone but she would go back and verify. States on Tuesday around 8:30p (m) she returned to the group home and checked the bubble card. States she checked the markings on the pill in the package and found the pills in the bubble card were Acetaminophen instead of Hydrocodone with the exception of one pill."</p> <p>The Conclusion of the investigation indicated, "Evidence supports 25 pills were taken from [client E's] Hydrocodone Bubble Card. Evidence does not support specific staff involvement with the missing Hydrocodone. Evidence supports proper counting procedures were followed according to staff report and controlled substance count documentation."</p> <p>The police report, dated 10/14/14, indicated, in part, "Spoke with [AD] of Indiana Mentor. She reported a theft of 26 Hydrocodone pills that were reported to her by staff to have been missing on 10-13-14 at around 4pm. Information was taken of staff who had access to medications. Physical Evidence was collected where I believe finger prints or DNA can be collected. I collected a copy of med logs from 10-9 to 10-14 who had distributed the meds. This case is under investigation at this time." A</p>			

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	<p>Supplemental Narrative, dated 10/14/14 at 10:44 PM, indicated, "25 pills of hydrocodone are missing."</p> <p>The Controlled Substance Inventory for client E's Hydrocodone, dated 9/5/14 to 10/14/14, indicated the most recent administration of client E's Hydrocodone was on 9/3/14 at 10:00 AM. From 9/3/14 at 10:00 AM to 10/13/14 at 4:00 PM, the medication count was 26.</p> <p>On 12/11/14 at 5:06 PM, staff #2 indicated she had worked at the group home for 13 years. Staff #2 indicated she did not take the medications and did not know who took the medications.</p> <p>On 12/11/14 at 5:20 PM, staff #6 indicated she had worked at the group home for 12 years. Staff #6 indicated client E's medications were double locked. Staff #6 indicated she was not sure who took the medications. Staff #6 indicated the medication was present on 10/10/14 when she and staff #2 counted the medications.</p> <p>On 12/11/14 at 5:21 PM, staff #3 indicated she counted the Hydrocodone on 10/13/14 at 4:00 PM. She indicated there were 3 pills missing. Staff #3 indicated she informed the Home Manager. Staff #3 indicated she did not</p>			

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	<p>know who took the medications.</p> <p>On 12/11/14 at 5:28 PM, the Home Manager (HM) indicated she was at the home on during the morning shift on 10/13/14. The Hydrocodone was counted and present. On 10/13/14 in the afternoon, staff #3 reported there were 3 pills missing. The HM indicated the Hydrocodone packaging had tape over the back of the package. The HM indicated the facility later discovered the Hydrocodone was missing and replaced with another medication. The HM indicated the controlled medications were counted at every medication pass and at shift change. The HM indicated the keys to the medication had been changed and continued to change. The HM indicated the pharmacy changed the packaging so a repeat occurrence could not happen.</p> <p>On 12/11/14 at 2:44 PM, the Area Director (AD) indicated the facility had one investigation related to 25 pills of Hydrocodone, a controlled medication, missing at the group home. The AD indicated the facility did not figure out who took the medications. The AD indicated all the staff were interviewed and no one knew who took the medications or admitted to taking the medications. The AD indicated there were a couple of windows that were open</p>			

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	<p>at the time. The AD indicated the exit doors automatically lock. The AD indicated the pills were prescribed for client E as an as needed medication. The AD indicated client E did not miss any doses. The AD indicated the pharmacy changed the packaging and the facility was not keeping as many pills in the home. The AD indicated the controlled medication counts were completed prior to the issue being found. The AD indicated it was obvious the packaging had been taped when she looked at the packaging. The AD indicated the investigation started when staff discovered 3 missing pills.</p> <p>On 12/11/14 at 3:04 PM, the AD indicated the BDDS report should have been submitted within 24 hours. The AD indicated the facility was trying to determine the full extent of the issue.</p> <p>On 12/11/14 at 3:04 PM, the Program Director (PD) indicated the BDDS report should have been submitted within 24 hours. The PD indicated the BDDS report was not submitted due to the number of pills that were missing changed. The PD indicated the facility did not know the full story until the 14th.</p> <p>The facility's policy and procedures were reviewed on 12/11/14 at 2:55 PM. The</p>						

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W000153	<p>facility's Quality and Risk Management policy dated April 2011 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." The policy indicated, "An initial report regarding an incident shall be submitted within twenty four (24) hours of: (a.) the occurrence of the incident; or (b.) the reporter becoming aware of or receiving information about an incident."</p> <p>This federal tag relates to complaint #IN00158079.</p> <p>9-3-2(a)</p> <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. Based on record review and interview for 1 of 11 incident/investigative reports</p>	W000153	1.What corrective action will be accomplished?	01/11/2015

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	<p>reviewed affecting client E, the facility failed to submit an incident report to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>Findings include:</p> <p>On 12/11/14 at 3:00 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 10/13/14 at 4:00 PM (reported to BDDS on 10/15/14), staff #3 counted client E's controlled medication, Hydrocodone. Staff #3 found the count was off by 3 pills. Staff #3 reported the issue to the Home Manager (HM). The HM and Area Director (AD) went to the home to count the pills and confirmed the pills were missing. It appeared the pills were all accounted for at the 7:00 AM medication pass on 10/13/14. All staff who were potentially in the house alone on 10/13/14 between 7:00 AM and 4:00 PM were suspended pending the outcome of the investigation. The HM, staff #3 and staff #5 were suspended. On 10/14/14 the AD was again at the home inspecting the medication packaging. At that time, the AD discovered a total of 25 Hydrocodone pills had been removed from the package and had been replaced with a similar looking pill (Tylenol). The AD notified the police and a report was</p>		<ul style="list-style-type: none"> · Training with Program Director regarding reporting incidents in a timely manner. <p>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All clients have the potential to be affected by this practice.</p> <p>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · Area Director will record reportable events on incident tracking form upon notification of events. · Program Director will submit report via Incident Reporting System and email to all applicable parties (including the Area Director) within 24 hours of incident. · Area Director will monitor all reportable events within a 24-hour period to ensure incidents have been reported. <p>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · Area Director and QA Specialist will monitor report monthly to ensure compliance with timeliness. 		

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W009999	<p>filed. The medication packaging was removed from the home by the police and will be used as part of the police investigation.</p> <p>On 12/11/14 at 3:04 PM, the AD indicated the BDDS report should have been submitted within 24 hours. The AD indicated the facility was trying to determine the full extent of the issue.</p> <p>On 12/11/14 at 3:04 PM, the Program Director (PD) indicated the BDDS report should have been submitted within 24 hours. The PD indicated the BDDS report was not submitted due to the number of pills that were missing changed. The PD indicated the facility did not know the full story until the 14th.</p> <p>This federal tag relates to complaint #IN00158079.</p> <p>9-3-2(a)</p> <p>State Findings</p> <p>The following Community Residential Facilities for Persons with</p>	W009999	<p>1.What is the date by which the systemic changes will be completed? January 11, 2015</p> <p>1.What corrective action will be accomplished? · Training with Program Director regarding reporting incidents in a timely manner.</p>	01/11/2015			

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	<p>Developmental Disabilities Rule was not met:</p> <p>460 IAC 9-3-1 Governing Body</p> <p>(b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division:</p> <p>11. An emergency intervention for the individual resulting from: a. a physical symptom, b. a medical or psychiatric condition, and c. any other event.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 1 of 11 incident/investigative reports reviewed affecting client G, the facility failed to submit an incident report in a timely manner to the Bureau of Developmental Disabilities Services (BDDS) for a hospital admission.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 12/11/14 at 3:00 PM and indicated the following:</p> <p>On 11/26/14 at 5:00 PM (reported to</p>		<p>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All clients have the potential to be affected by this practice.</p> <p>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> · Area Director will record reportable events on incident tracking form upon notification of events. · Program Director will submit report via Incident Reporting System and email to all applicable parties (including the Area Director) within 24 hours of incident. · Area Director will monitor all reportable events within a 24-hour period to ensure incidents have been reported. <p>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · Area Director and QA Specialist will monitor report monthly to ensure compliance with timeliness. <p>1.What is the date by which the systemic changes will be completed?</p>				

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	<p>BDDS on 11/28/14), client G was experiencing fatigue and slurred speech. The facility's nurse recommended transporting client G to the hospital. Once at the hospital, lab work and a CT (computed tomography) scan were completed. Tested revealed possible renal issues and possible issues with her shunt. Client G was admitted to the hospital for further treatment.</p> <p>On 12/11/14 at 3:04 PM, the Area Director (AD) indicated the BDDS report should have been submitted within 24 hours.</p> <p>On 12/11/14 at 3:04 PM, the Program Director (PD) indicated the BDDS report should have been submitted within 24 hours.</p> <p>9-3-1(b)</p>		January 11, 2015		