

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362
---	---

(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	<p>This visit was for a full recertification and state licensure survey.</p> <p>Dates of Survey: February 18, 19, 20, and 21, 2014.</p> <p>Facility number: 005553 Provider number: 15G735 AIM number: 200854080</p> <p>Surveyor: Susan Reichert, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 3/3/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview for 3 of 3 sampled clients (#1, #2, and #3) and for 4 additional clients (#4, #5, #6, #7 and #8), the governing body failed to exercise</p>	W000104	<p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>1. What corrective action</p>	03/23/2014

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2014	
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362			
(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>general policy and operating direction over the facility to ensure the home was maintained in good condition.</p> <p>Findings include:</p> <p>Observations were completed at the group home on 2/18/14 from 5:10 PM until 6:50 PM. The loveseat in the living room used by clients #1, #2, #3, #4, #5, #6, #7 and #8 had 5 tears in the upholstery exposing the padding ranging in size from 2 inches by 1 inch to 4 inches by 1 inch. The sofa had 8 tears in the upholstery exposing the padding ranging in size from 2 inches by 1 inch to 4 inches by 2 inches. The fluorescent lighting in the bathroom and the laundry/medication/supply room used by clients #1, #2, #3, #4, #5, #6, #7 and #8 flickered on and off. There was a carpet tear next to the sofa and love seat in the living room that was 6 inches in length.</p> <p>The house manager was interviewed on 2/18/14 at 6:14 PM. She indicated new furniture was in the process of being ordered for the home, but was uncertain of plans to repair or replace the torn carpet.</p> <p>Staff #4 was interviewed on 2/18/14 at 6:15 PM and indicated the fluorescent lighting had been flickering for two days.</p> <p>Observations were completed at the group home on 2/19/14 from 7:17 AM until 8:10 AM. There was a floor mat hanging on the handrail of the wall across from the</p>		<p>will be accomplished?</p> <ul style="list-style-type: none"> · The furniture for the group home is ordered. · The holes in the walls were fixed on 3/6/14. · The bleach stained bedding has been discarded. The home had bedding available that was not bleach stained and in good condition. · Staff will be re-trained on not placing sub-par bedding on client's beds in the team meeting on 3/21/2014 · The lighting in the home was fixed (new bulbs and new ballasts) on 3/6/14. Staff will be re-trained on reporting maintenance issues to home manager on 3/21/14. <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. · The holes in the walls were fixed on 3/6/14. · The bleach stained bedding has been discarded. The home had bedding available that was not bleach stained and in good condition. · Staff will be re-trained on not placing sub-par bedding on client's beds in the team meeting on 3/21/2014 · The lighting in the home was fixed (new bulbs and new 				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2014	
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362			
(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>laundry/medication/supply room and next to a bathroom. There was a red bracket without anything attached hanging by the back door to the home. There were more than 30 bleach stains on the sheets on client #7's bed.</p> <p>Staff #8 was interviewed on 2/19/14 at 7:17 AM. When asked about the purpose of the mat, staff #8 stated it was "To protect [client #7] when he gets to rocking," and slid the mat to one side of the railing exposing a 17 inch by 6 inch depression in the drywall pushed completely through the width of the drywall. He indicated the hole and other 5 other holes in the wall of the hallway measuring in size from 4 inches by 4 inches to 11 inches by 6 inches were caused by client #7's back when he rocked back and forth. He indicated client #7 had a plan to address his rocking behavior which included using a ball and redirection to activity other than rocking.</p> <p>Staff #1 was interviewed on 2/19/14 at 8:15 AM and indicated he was uncertain of the status of maintenance repairs of the walls and indicated the fluorescent lighting had been flickering for a week.</p> <p>The house manager was interviewed on 2/19/14 at 8:40 AM. She indicated client #7's sheets should not have been bleach stained and indicated the red bracket was to attach a fire extinguisher to the wall. She was uncertain of the whereabouts of the fire extinguisher. She indicated the maintenance</p>		<p>ballasts) on 3/6/14. Staff will be re-trained on reporting maintenance issues to home manager on 3/21/14.</p> <ul style="list-style-type: none"> · Quarterly health and safety checks will be conducted that will include checks to ensure the home furnishings and home are not at sub-par standards. <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"> · The furniture for the group home is ordered and being delivered. · The holes in the walls were fixed on 3/6/14. · The bleach stained bedding has been discarded. The home had bedding available that was not bleach stained and in good condition. · Staff will be re-trained on not placing sub-par bedding on client's beds in the team meeting on 3/21/2014. · The lighting in the home was fixed on 3/6 it no longer flickers. Staff will be re-trained on reporting maintenance issues to home manager on 3/21/2014. <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · Quarterly health and safety checks will be conducted that will include checks to ensure the 				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2014	
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362			
(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>had recently repaired the fluorescent lighting, and was uncertain of the status of maintenance work orders to repair the home.</p> <p>A Request for Payment (RFP) dated 1/28/14 was reviewed on 2/20/14 at 12:48 PM and indicated the amount of \$750 "This is for a new couch and love seat. Will order and have delivered."</p> <p>The Area Director was interviewed on 2/20/14 at 12:50 PM and indicated the request for a new sofa and loveseat had been submitted and was in process, but the request had not been yet been approved.</p> <p>Maintenance Request Forms from February, 2013 to February, 2014 were reviewed on 2/20/14 at 9:30 AM. An entry dated 1/5/14 indicated "holes in wall by 2nd bathroom," an entry dated 1/10/14 indicated "lights flicker in 2nd bathroom," an entry dated 1/7/14 indicated "fire extinguisher off the wall by back door," and an entry dated 1/22/14 indicated "additional holes in hallway." The section indicating "Date Completed" next to the entries was blank.</p> <p>The Area Director, Program Director #1 and Program Director #2 were interviewed on 2/20/14 at 2:40 PM. The Area Director indicated maintenance was to make repairs to the home to address the issues noted on the maintenance form, and the flooring was planned to be repaired/replaced.</p>		<p>home furnishings and home are not at sub-par standards.</p> <ul style="list-style-type: none"> The program director and/or area direction will review the quarterly documentation <p>5. What is the date by which the systemic changes will be completed?</p> <ul style="list-style-type: none"> March 23rd, 2014 				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2014	
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362			
(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			
W000148	<p>9-3-1(a)</p> <p>483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.</p> <p>Based on record review and interview for 8 of 42 reportable incidents reviewed, the facility failed to notify clients #1, #2, and #3's legally authorized representatives of incidents of use of restraint (clients #1 and #2) and incidents of physical aggression (clients #1 and #2).</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 2/18/14 at 3:55 PM. The review indicated the following BDDS reports:</p> <p>For client #1:</p>	W000148	<p>The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.</p> <p>1. What corrective action will be accomplished? · The program director will be trained on notifying guardians, parents, and/or health care representatives of any significant incidents or changes in the client's condition on 3/21/14.</p> <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? · All residents have the potential to be affected by the</p>	03/23/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2014	
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362			
(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>-A BDDS report dated 1/7/14 indicated client #1 "became physically aggressive with a peer...a few minutes later [client #1] became physically aggressive toward staff and appeared that he could physically aggression (sic) toward other clients as well." The report indicated "redirection was unsuccessful, so physical restraint was used as the least restrictive measure. [Client #1] was placed in the Primary Restraint Technique (PRT) per his BSP (Behavior Support Plan)," and indicated the restraint was used for 30 minutes before client #1 became calm. The section of the report to indicate guardian notification of the incident was marked N/A (non applicable).</p> <p>-A BDDS report dated 1/21/14 indicated client #1 was placed in restraint twice after becoming "combative" hitting and attempting to hit a peer. The section of the report to indicate guardian notification of the incident was marked N/A (non applicable).</p> <p>-A BDDS report dated 1/25/14 indicated a PRT was used with client #1 after becoming "combative" and unable to be redirected. The section of the report to indicate guardian notification of the incident was marked N/A (non applicable).</p> <p>-A BDDS report dated 1/30/14 indicated a PRT was used with client #1 after he became physically aggressive. The section of the report to indicate guardian notification of the incident was marked N/A (non applicable).</p> <p>For client #2:</p> <p>-A BDDS report dated 1/14/14 indicated client #2 was restrained at workshop after she began to run for a busy road. The section of the report to</p>		<p>same deficient practice.</p> <ul style="list-style-type: none"> · The program director will be trained on notifying guardians, parents, and/or health care representatives of any significant incidents or changes in the client's condition on 3/21/14. <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"> · The program director will be trained on notifying guardians, parents, and/or health care representatives of any significant incidents or changes in the client's condition on 3/21/14. <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 area director will monitor the BDDS reports submitted by the program director. <p>5. What is the date by which the systemic changes will be completed?</p> <ul style="list-style-type: none"> · March 23rd, 2014 				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362
---	---

(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>indicate guardian notification of the incident was marked N/A (non applicable).</p> <p>-A BDDS report dated 2/9/14 at 6:14 PM indicated client #2 was placed in a PRT after she began to run for the road. The section of the report to indicate guardian notification of the incident was marked N/A (non applicable).</p> <p>-A BDDS report dated 2/9/14 at 6:40 PM indicated client #2 was placed in a PRT after becoming physically aggressive. The section of the report to indicate guardian notification of the incident was marked N/A (non applicable).</p> <p>Client #1's record was reviewed on 2/20/14 at 1:45 PM and indicated he had a guardian.</p> <p>Client #2's record was reviewed on 2/20/14 at 12:25 PM and indicated she had a guardian.</p> <p>The Area Director was interviewed on 2/20/14 and indicated there was no documented evidence of client #1 and #2's guardians being notified of the incidents of restraint and physical aggression.</p> <p>9-3-2(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2014	
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362			
(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			
W000159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>Based on record review and interview for 4 of 4 sampled clients (clients #1, #2, #3 and #4) the QIDP (Qualified Intellectual Disabilities Professional) failed to ensure objectives included in Individual Support Plans were revised when criteria was met, and failed to review and include vocational assessments in the client record for 4 of 4 sampled clients (clients #1, #2, #3, and #4). The QIDP failed to ensure assessment/evaluation recommendations were addressed for 1 of 4 sampled clients (client #3) and 1 additional client (client #7).</p> <p>Findings include:</p> <p>1. Client #1's record at the facility was reviewed on 2/20/14 at 1:45 PM. An ISP (Individual Support Plan) dated 12/10/13 included objectives to initiate coping techniques, answer medication questions, mail correspondence to</p>	W000159	<p>Each client's active treatment program just be integrated, coordinated, and monitored by a qualified mental retardation professional.</p> <p>1. What corrective action will be accomplished? · The program director will be trained on revising goals where the criteria for completion has been met 3/21/14. · The program director will be trained on gaining the vocational assessments or progress from workshop 3/21/14 · A communication board will be provided for client #7. · Client #3's ISP will be updated with an objective to address his needs in tooth brushing.</p> <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? · All residents have the potential to be affected by the same deficient practice</p>	03/23/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362		
(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>family and identify coins. Client #1's record indicated he had met the criteria established at 100% accuracy. There was no evidence in the record of a revision of client #1's objectives when he met criteria.</p> <p>Client #2's record was reviewed on 2/20/14 at 12:25 PM. Client #2's ISP dated 3/12/13 included objectives to name medication and it's purpose, identify consequences of actions, make change, state/utilize ways she can cope with frustrations, clean room and change bed linens, recognize staff names, and independently complete her personal morning routine. Client #2's record indicated she had met the criteria established at 100% accuracy. There was no evidence in the record of a revision of client #2's objectives when she met criteria.</p> <p>Client #3's record was reviewed on 2/20/14 at 1:15 PM. Client #3's ISP dated 7/11/13 indicated objectives to clean his bedroom, independently give receipts to staff for purchases, name medication and it's purpose, independently shower, set the table for dinner, and identify the importance of not accusing peers. The record indicated he had met the criteria established at 100% accuracy. There was no evidence</p>		<ul style="list-style-type: none"> · The program director will be trained on revising goals where the criteria for completion has been met. · The program director will be trained on gaining the vocational assessments or progress at workshop · A communication board will be provided for client #7. · Client #3's ISP will be updated with an objective to address his needs in tooth brushing. · Program director will ensure all communication recommendations from the speech therapist will be implemented <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"> · The program director will be trained on revising goals where the criteria for completion has been met. · The program director will be trained on gaining the vocational assessments or progress at workshop · A communication board will be provided for client #7. · Client #3's ISP will be updated with an objective to address his needs in tooth brushing. · Program director will ensure all communication recommendations from the 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2014	
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362			
(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>of a revision of client #3's objectives when he met criteria.</p> <p>Client #4's record at the facility was reviewed on 2/20/14 at 10:38 AM. An Individual Support Plan dated 10/24/13 indicated objectives to independently set the dial on the washer, independently brush her teeth, independently operate the dishwasher, independently cook a main dish, independently match a bill currency to the correct amount, and to independently gather items for medication administration. The record indicated she had met the criteria established at 100% accuracy. There was no evidence of a revision of client #4's objectives when she met criteria.</p> <p>The Area Director (AD) and Program Director (PD) were interviewed on 2/20/14 at 2:40 PM. The AD indicated the clients' objectives should have been revised when met.</p> <p>2. Client #1's record at the workshop was reviewed on 2/19/14 at 10:45 AM. A vocational assessment dated 8/22/13 indicated he was independent in vocational skills with the exception of requiring verbal prompts to stay on task and ability to thoroughly complete work. The assessment indicated an objective to maintain progress at 4%.</p>		<p>speech therapist will be implemented</p> <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 area director will review goal documentation on at least a quarterly basis · The area director will review ISPs for vocational assessments · Client #3's tooth brushing needs will be added to the MAR and formal programming to assist with tooth brushing will be implemented to ensure monitoring · Program director will ensure all communication recommendations from the speech therapists will be implemented <p>5. What is the date by which the systemic changes will be completed?</p> <ul style="list-style-type: none"> · March 23rd 2014 				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362
---	---

(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>Client #1's record at the facility was reviewed on 2/20/14 at 1:45 PM. The record did not include a vocational assessment or evidence client #1's QIDP (Qualified Intellectual Disabilities Professional) reviewed his vocational assessment or his progress at the workshop.</p> <p>Client #2's record was reviewed at the workshop on 2/19/14 at 10:46 AM. A vocational assessment dated 3/12/13 indicated client #2 was independent in vocational skills with the exception of "checks and corrects own work" where she required physical assistance and verbal prompts to stay on task. An Annual Program Report dated 3/12/13 indicated an objective to maintain a production rate of 5%.</p> <p>Client #2's record at the facility was reviewed on 2/20/14 at 12:35 PM. The record did not include a vocational assessment or evidence client #2's QIDP reviewed her vocational assessment or her progress at the workshop.</p> <p>Client #3's record at the workshop was reviewed on 2/19/14 at 10:50 PM. A vocational assessment dated 7/11/13 indicated client #3 required verbal prompts and physical prompts to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2014	
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362			
(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>perform vocational skills except for obtains more work when needed, asks for assistance, works cooperatively with co-workers, appropriate social interaction with peers, visitors and others, ability to thoroughly complete work in which he performed independently. An Annual Program Report dated 7/12/13 indicated client #3 had an objective to maintain a production rate of 8.4%.</p> <p>Client #3's records at the facility were reviewed on 2/20/14 at 1:15 PM. The record did not include a vocational assessment or evidence client #3's QIDP reviewed his vocational assessment or his progress at the workshop.</p> <p>Client #4's record at the workshop was reviewed on 2/19/14 at 10:30 AM. A Case Conference Minutes Admission ISP (Individual Support Plan) form dated 9/23/13 indicated workshop safety rules were discussed with client #4 and client #4 "signed her documents to begin workshop." Client #4's record did not include evidence of a vocational assessment to determine her skills and interests.</p> <p>The workshop Service Coordinator was interviewed on 2/19/14 at 10:36 AM and indicated she had not completed a</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2014	
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362			
(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>vocational assessment for client #3 and it had been overlooked.</p> <p>The workshop Service Coordinator was interviewed on 2/19/14 at 10:36 AM and indicated she had not completed a vocational assessment for client #4 and it had been overlooked. She indicated she had not provided vocational assessments to client #1, #2, #3, and #4's QIDP as they had not requested them and indicated most other facilities had requested them. She was uncertain why the facility had not requested a copy of their vocational assessments.</p> <p>Client #4's record at the facility was reviewed on 2/20/14 at 10:38 AM. An Individual Support Plan dated 10/24/13 did not include a vocational assessment of her skills and interests. The record did not include evidence client #4's QIDP reviewed her progress at the workshop.</p> <p>The Area Director was interviewed on 2/20/14 at 2:40 PM and indicated client #4's vocational skills should have been assessed. He indicated clients #1, #2, and #3's vocational assessments and progress should have been reviewed by the QIDP and included in their facility records.</p> <p>3. Observations were completed at the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2014	
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362			
(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>group home on 2/18/14 from 5:10 PM until 6:50 PM. Client #7 sat on the floor in the living room rocking and making verbalizations. The house manager rubbed his back when verbalizations and rocking increased in intensity. Client #7 finished his dinner quickly and returned to the living room. Staff #4 asked client #7 if he wanted more food, but he did not respond. There was no evidence of a communication board in use during the observation.</p> <p>During observation at the workshop on 2/19/14 from 9:15 AM until 10:15 AM, client #7 sat on the floor rocking and smiling, and then got up into a chair and worked on an arts and crafts project with staff assistance.</p> <p>The workshop manager was interviewed on 2/19/14 at 9:30 AM and indicated the staff had made a communication board for client #7 and he used it to identify staff, toilet and food and drink pictures. She indicated the staff had completed the board based upon his needs for communication at workshop and not based upon a speech and language evaluation provided to them.</p> <p>Client #7's record was reviewed on 2/20/14 at 2:00 PM. A Speech-Language Evaluation dated 8/11/13 indicated</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2014	
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362			
(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>recommendations to use a specific photo communication picture to request a specific activity and to informally encourage client #7 to engage client #7 to participate in social activities to promote vocabulary and language development. There was no evidence in the record of goals to address the speech evaluation recommendations.</p> <p>Client #3's record was reviewed on 2/20/14 at 1:15 PM. A dental examination dated 11/11/13 indicated a recommendation to brush his teeth twice daily. His 7/11/13 ISP did not include an objective to address his needs in toothbrushing.</p> <p>The Area Director and Program Director were interviewed on 2/20/14 at 2:40 PM. The Program Director indicated an electronic communication system had been attempted without success for client #7, but the recommendations for a picture communication system had not been implemented at the group home and there was not a goal for toothbrushing to address client #3's needs in oral hygiene. The Area Director indicated recommendations should be addressed in client plans by the QIDP.</p> <p>9-3-3(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2014	
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362			
(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			
W000164	<p>483.430(b)(1) PROFESSIONAL PROGRAM SERVICES Each client must receive the professional program services needed to implement the active treatment program defined by each client's individual program plan.</p> <p>Based on observation, record review and interview for 3 of 3 sampled clients (clients #1, #2, and #3), the facility failed to assure the professional program services clinician (behavioral consultant) was available in the group home and at the facility operated day services to develop and ensure implementation of their behavior plans.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 2/18/14 at 3:55 PM. The review indicated</p>	W000164	<p>Each client must receive the professional program services needed to implement the active treatment program defined by each client's individual program plan.</p> <p>1. What corrective action will be accomplished? · The BSPs for clients #1 and #2 were sent to Fritz Kruggel, the lead behavioral specialist for Indiana Mentor, for review on 3/11/14. · Indiana Mentor's Behavior department will decide revisions to make to the behavior plan, and it will be revised per those guidelines. · Ongoing training will be provided as needed by Indiana</p>	03/23/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2014	
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362			
(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>the following BDDS reports:</p> <p>For client #1:</p> <p>-A BDDS report dated 5/22/13 indicated client #1 was placed in "primary restraint" for 15 minutes at the workshop after biting and scratching his staff member. Corrective action indicated an IDT (interdisciplinary team) meeting was held and client #1 was to placed in a "hab (habilitation) room" at workshop as it was smaller and less stimulating for him.</p> <p>-A BDDS report dated 6/13/13 indicated client #1 was restrained for 22 minutes after punching a male staff member in the kidney and biting him. Corrective action indicated a team meeting would be held to discuss his aggressive behaviors at work and client #1's Behavior Support Plan would be followed.</p> <p>-A BDDS report dated 1/7/14 indicated client #1 "became physically aggressive with a peer...a few minutes later [client #1] became physically aggressive toward staff and appeared that he could physically aggression (sic) toward other clients as well." The report indicated "redirection was unsuccessful, so physical restraint was used as the least restrictive measure. [Client #1] was placed in the Primary Restraint Technique (PRT) per his BSP (Behavior Support Plan)," and indicated the restraint was used for 30 minutes before client #1 became calm. Corrective action indicated client #1's BSP was to be continued and staff were being retrained on his BSP on 1/10/14.</p> <p>-A BDDS report dated 1/21/14 indicated client #1 was placed in restraint twice after becoming "combative" hitting and attempting to hit a peer. Corrective action indicated client #1's BSP was</p>		<p>Mentor's Behavioral Services department.</p> <p>2. How will we identify other residents have 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 · Program Director will review all BDDS reports and behavioral data on a monthly basis. If trends in maladaptive behavior arise the program director will contact behavioral services for possible revisions to the BSP. · Area director will review all BDDS reports and behavioral data on a monthly basis. <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"> · The BSPs for clients #1 and #2 were sent to Fritz Kruggel, the lead behavioral specialist for Indiana Mentor, for review on 3/11/14. · Indiana Mentor's Behavior department will decide revisions to make to the behavior plan, and it will be revised per those guidelines. · Ongoing training will be provided as needed by Indiana Mentor's Behavioral Services department. 				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2014	
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362			
(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>to be continued and staff were being retrained on his BSP.</p> <p>-A BDDS report dated 1/25/14 indicated a PRT was used with client #1 after becoming "combative" and unable to be redirected. Corrective action indicated client #1's medications were being changed by his psychiatrist, and client #1's BSP was to be continued. Corrective action indicated client #1's BSP was to be continued.</p> <p>-A BDDS report dated 1/30/14 indicated a PRT was used with client #1 after he became physically aggressive. Corrective action indicated client #1's medications were being changed by his psychiatrist, and client #1's BSP was to be continued.</p> <p>For client #2:</p> <p>-A BDDS report dated 2/19/13 indicated she was hit by client #1 at the group home causing redness. Corrective action indicated client #2 would be monitored for bruising and client #1 had a plan to address physical aggression.</p> <p>-A BDDS report dated 5/19/13 indicated client #2 was restrained after taking a swing at staff. Corrective action indicated client #2's BSP would be continued.</p> <p>-A BDDS report dated 6/8/13 indicated client #2 was restrained after throwing items at staff. Corrective action indicated client #2's plan world be continued.</p> <p>-A BDDS report dated 1/14/14 indicated client #2 was restrained at workshop after she began to run for a busy road. Corrective action indicated client #2's plan world be continued.</p>		<p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · Program Director will review all BDDS reports and behavioral data on a monthly basis. If trends in maladaptive behavior arise the program director will contact behavioral services for possible revisions to the BSP. · Area director will review all BDDS reports and behavioral data on a monthly basis. <p>5. What is the date by which the systemic changes will be completed?</p> <ul style="list-style-type: none"> · March 23rd, 2014 				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2014	
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362			
(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>-A BDDS report dated 2/9/14 at 6:14 PM indicated client #2 was placed in a PRT after she began to run for the road. Corrective action indicated client #2's plan would be continued.</p> <p>-A BDDS report dated 2/9/14 at 6:40 PM indicated client #2 was placed in a PRT after becoming physically aggressive. Corrective action indicated client #2's plan would be continued.</p> <p>Client #1's record was reviewed on 2/20/14 at 1:45 PM. A BSP dated 6/27/13 indicated target behaviors of agitation, SIB (self injurious behavior, verbal aggression and physical aggression. The plan included the use of psychotropic medication and physical restraint to address behavior. There was no evidence the plan had been developed by a behavior clinician.</p> <p>Client #2's record was reviewed on 2/20/14 at 12:25 PM. A BSP dated 2/14/14 indicated targeted behaviors of tantrums, physical aggression, property destruction, non-compliance, elopement and disruptive behavior. The plan included the use of psychotropic medication and physical restraint to address her behaviors. There was no evidence the plan had been developed by a behavior clinician.</p> <p>The Area Director was interviewed on 2/20/14 at 2:20 PM and indicated there was no involvement of a behavior clinician to develop, provide ongoing staff training and oversight of implementation of plans to address behavior for clients #1 and #2, but was planned for the future.</p> <p>9-3-3(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362
---	---

(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
W000198	<p>483.440(b)(1) ADMISSIONS, TRANSFERS, DISCHARGE Clients who are admitted by the facility must be in need of and receiving active treatment services.</p> <p>Based on observation, interview, and record review, the facility failed by continuing to admit 1 of 4 sampled clients (client #4) who was not in need of continuous and aggressive active treatment.</p> <p>Findings include:</p> <p>During the observation period on 2/18/14 from 5:15 PM until 6:50 PM, client #4 set the table, ate her meal, and participated in meal clean up without direction or assistance from staff.</p> <p>Client #4 was interviewed on 2/18/14 at</p>	W000198	<p>Clients who are admitted by the facility must be in need of and receiving active treatment services.</p> <ol style="list-style-type: none"> What corrective action will be accomplished <ul style="list-style-type: none"> More appropriate placement for client #4 has been initiated and BDDS has been contacted regarding the W 198. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. <ul style="list-style-type: none"> When in the home daily the home manager will monitor for all clients benefiting from staffing and active treatment. The program director will 	03/23/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2014	
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362			
(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>6:15 PM. She indicated she liked it at the group home and stated, "I was headed toward prison on my previous path." She indicated she had raised her siblings and stated she had "bounced back and forth" between living with her biological parents and foster care. She indicated she liked assisting the clients at the group home and stated she wanted to "get a second job."</p> <p>During observation at the group home, client #4 came from the bathroom with a towel wrapped around her head. She indicated she had just washed her hair. During administration of medication, client #4 got her medications from the storage area, named the pills and their purpose. She indicated she was able to identify and name the purpose of her medications.</p> <p>During observation at the workshop on 2/19/14 from 9:15 AM until 10:15 AM, client #4 worked steadily loading materials on a pallet without assistance or direction from staff. Client #4 initiated a statement during observation of her work station which indicated she had already learned several jobs at the workshop since starting employment on 9/23/13.</p> <p>The workshop supervisor was</p>		<p>review goal documentation at least quarterly for trends in clients obtaining independence with ADLs.</p> <ul style="list-style-type: none"> · The area director will review goal documentation at least quarterly for trends in clients obtaining independence with ADLs. <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"> · When in the home daily the home manager will monitor for all clients benefiting from staffing and active treatment. · The program director will review goal documentation at least quarterly for trends in clients obtaining independence with ADLs. · The area director will review goal documentation at least quarterly for trends in clients obtaining independence with ADLs. <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · When in the home daily the home manager will monitor for all clients benefiting from staffing and active treatment. · The program director will review goal documentation at least quarterly for trends in clients not needing staff assistance with ADLs, money management, and 				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362
---	---

(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>interviewed on 2/19/14 at 9:20 PM. She indicated the group home staff would need to refer client #4 to vocational rehabilitation services for community employment, and client #4 had good vocational skills.</p> <p>Client #4's record was reviewed on 2/20/14 at 10:38 AM. An Individual Support Plan dated 10/24/13 indicated objectives to independently set the dial on the washer, independently brush her teeth, independently operate the dishwasher, independently cook a main dish, independently match a bill currency to the correct amount, and to independently gather items for medication administration. Monthly reviews of the objectives from November, 2013 to February, 2014 indicated she had met criteria for mastery of the objectives. An Informed Consent Assessment dated 10/24/13 indicated client #4 was able to make decisions regarding routine medical and dental care, medical procedures and surgeries, routine medication, psychotropic medication with formal/informal counseling and verbal cues. The form indicated client #4 was an emancipated adult. An Individual Plan of Protective Oversight dated 10/24/13 indicated client #4 was able to explain medical information to medical</p>		<p>etc.</p> <ul style="list-style-type: none"> · The area director will review goal documentation at least quarterly for trends in clients not needing staff assistance with ADLs, money management, and etc. <p>5. What is the date by which the systemic changes will be completed?</p> <ul style="list-style-type: none"> · March 23rd, 2014 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2014	
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362			
(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>professionals "with staff assistance to put it in true perspective. [Client #4] can over state the extent of an issue." The plan of oversight indicated client #4 was able to apply simple first aid, can self medicate with staff supervision, was able to identify healthy choices and appropriate quantities with staff assistance, able to complete all aspects of oral hygiene with staff supervision for completion, was aware of her personal rights and able to protect herself, able to consent to medical procedures, able to evacuate independently and behavioral concerns indicated she "may try to assist others rather than evacuate herself," required staff supervision in for completion for complete personal hygiene, able to handle money amount to be determined by the IDT (interdisciplinary team), able to select clothing with staff assistance in event appropriateness, able to dress self, complete laundry, able to complete household tasks with prompts, and able to use appliances with staff supervision in the laundry and kitchen.</p> <p>The Area Director was interviewed on 2/20/14 at 2:40 PM. When asked if client #4 was appropriately placed at the group home, he stated, "No" and indicated while client #4 required 24 hour supervision, she did not need more</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362
---	---

(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
W000209	<p>than reminders or verbal prompts to complete adult daily living skills. He indicated client #4 came to the group home as an emergency admission to protect her from exploitation in her previous home environment and had demonstrated independence with staff oversight to ensure completion since her admission. He indicated client #4 did not require the structure of a group home, continuous and aggressive prompts by staff to complete adult daily living skills and stated, "If she stays much longer, she will decompensate."</p> <p>9-3-4(a)</p> <p>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, the facility failed to facilitate guardian/health care representative participation in the development of an</p>	W000209	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	03/23/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362		
(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>Individual Support Program Plan (ISP) for 3 of 4 sampled clients (clients #1, #2, and #3).</p> <p>Findings include:</p> <p>Client #1's records were reviewed on 2/20/14 at 1:45 PM. Client #1's record indicated he had a guardian. Client #1's record included an ISP dated 12/10/13. There was no documentation to indicate client #1's guardian had participated in the development of client #1's ISP.</p> <p>Client #2's record was reviewed on 2/20/14 at 2:25 PM. Client #2's record indicated she had a guardian. Client #2's record included an ISP dated 3/2/13. There was no documentation to indicate client #2's guardian had participated in the development of client #2's ISP.</p> <p>Client #3's record was reviewed on 2/20/14 at 1:15 PM. Client #3's record indicated he had a health care representative. Client #3's record indicated he had an ISP dated 7/11/13. There was no documentation to indicate client #3's health care representative had participated in the development of client #3's ISP.</p> <p>The Area Director was interviewed on 2/20/14 at 2:40 PM and indicated client</p>		<p>inappropriate.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · The program director will be retrained on involving the client's guardian/healthcare representative in the development of the client's ISP on 3/21/14. · Client #2's yearly ISP for 2014 was held on 2/25/14. The legal guardian was present and signed the yearly ISP signature sheet saying she was present. <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 except two individuals who are emancipated adults · The program director will be retrained on involving the client's guardian/healthcare representative in the development of the client's ISP. <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"> · The program director will be retrained on involving the client's guardian/healthcare representative in the development of the client's ISP. 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2014	
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362			
(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			
W000225	<p>#1's guardian traveled for a living and it was difficult to obtain signatures at times from him at times. He indicated there was no additional evidence that client #2's guardian and #3's health care representative had participated in the development of their plans.</p> <p>9-3-4(a)</p> <p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include, as applicable, vocational skills.</p> <p>Based on observation, record review and interview, the facility failed to assess vocational skills and interests for 1 of 4 sampled clients (client #4).</p> <p>Findings include:</p> <p>During observation at the workshop on 2/19/14 from 9:15 AM until 10:15 AM, client #4 worked steadily loading materials on a pallet without assistance or direction from staff. Client #4 initiated a statement during observation of her work station which indicated she had already learned several jobs at the workshop since starting employment on</p>	W000225	<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 program director will monitor the yearly ISP paperwork to ensure that the guardian/healthcare representative was involved in the yearly implementation of the ISP. <p>5. What is the date by which the systemic changes will be completed?</p> <ul style="list-style-type: none"> March 23rd, 2014 <p>The comprehensive functional assessment must include, as applicable, vocational skills.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> The program director will be re-trained on ensuring the completion of vocational assessments on 3/21/14 <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 The program director will be re-trained on ensuring the 	03/23/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362		
(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>9/23/13.</p> <p>The workshop manager was interviewed on 2/19/14 at 9:20 PM. She indicated the group home staff would need to refer client #4 to vocational rehabilitation services for community employment, and client #4 had good vocational skills.</p> <p>Client #4's record at the workshop was reviewed on 2/19/14 at 10:30 AM. A Case Conference Minutes Admission ISP (Individual Support Plan) form dated 9/23/13 indicated workshop safety rules were discussed with client #4 and client #4 "signed her documents to begin workshop." Client #4's record did not include evidence of a vocational assessment to determine her skills and interests.</p> <p>The workshop Service Coordinator was interviewed on 2/19/14 at 10:36 AM and indicated she had not completed a vocational assessment for client #4 and it had been overlooked.</p> <p>Client #4's record was reviewed on 2/20/14 at 10:38 AM. There was no evidence in the record of a vocational assessment.</p> <p>The Area Director was interviewed on 2/20/14 at 2:40 PM and indicated client</p>		<p>completion of vocational assessments on 3/21/14.</p> <ul style="list-style-type: none"> · The area director will review the annual ISP for vocational assessments <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"> · The program director will be re-trained on ensuring the completion of vocational assessments on 3/21/14. · The area director will review the annual ISP for vocational assessments <p>4. How will corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · The area director will review the annual ISP for vocational assessments <p>5. What is the date by which the systemic changes will be completed?</p> <ul style="list-style-type: none"> · March 23rd, 2014 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2014	
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362			
(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			
W000227	<p>#4's vocational skills should have been assessed.</p> <p>9-3-4(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on observation, interview and record review for 1 of 4 sampled clients (client #3), and 1 additional client (client #7) the Individual Support Plan (ISP) failed to address their specific needs in the area of toothbrushing and communication skills.</p> <p>Findings include:</p> <p>Observations were completed at the group home on 2/18/14 from 5:10 PM until 6:50 PM. Client #7 sat on the floor in the living room rocking and making verbalizations.</p>	W000227	<p>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>1. What corrective action will be accomplished? · The program director will be trained on revising goals where the criteria for completion has been met. · The program director will be trained on gaining the vocational assessments or progress from workshop</p>	03/23/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2014	
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362			
(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>The house manager rubbed his back when verbalizations and rocking increased in intensity. Client #7 finished his dinner quickly and returned to the living room. Staff #4 asked client #7 if he wanted more food, but he did not respond. There was no evidence of a communication board in use during the observation.</p> <p>During observation at the workshop on 2/19/14 from 9:15 AM until 10:15 AM, client #7 sat on the floor rocking and smiling, and then got up into a chair and worked on an arts and crafts project with staff assistance.</p> <p>The workshop manager was interviewed on 2/19/14 at 9:30 AM and indicated the staff had made a communication board for client #7 and he used it to identify staff, toilet and food and drink pictures. She indicated the staff had completed the board based upon his needs for communication at workshop and not based upon a speech and language evaluation provided to them.</p> <p>Client #7's record was reviewed on 2/20/14 at 2:00 PM. A Speech-Language Evaluation dated 8/11/13 indicated recommendations to use a specific photo communication picture to request a specific activity and to informally encourage client #7 to engage client #7 to participate in social activities to promote vocabulary and language development. There was no evidence in the record of goals to address the speech</p>		<ul style="list-style-type: none"> · A communication board will be provided for client #7. · Client #3's ISP will be updated with an objective to address his needs in tooth brushing. <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 · The program director will be trained on revising goals where the criteria for completion has been met. · The program director will be trained on gaining the vocational assessments or progress at workshop · Workshop on providing vocational assessments on all clients. · A communication board will be provided for client #7. · Client #3's ISP will be updated with an objective to address his needs in tooth brushing. · Program director will ensure all communication recommendations from the speech therapist will be implemented <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362		
(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>evaluation recommendations.</p> <p>Client #3's record was reviewed on 2/20/14 at 1:15 PM. A dental examination dated 11/11/13 indicated a recommendation to brush his teeth twice daily. His 7/11/13 ISP did not include an objective to address his needs in toothbrushing.</p> <p>The Area Director and Program Director were interviewed on 2/20/14 at 2:40 PM. The Program Director indicated an electronic communication system had been attempted without success for client #7, but the recommendations for a picture communication system had not been implemented at the group home and there was not a goal for toothbrushing to address client #3's needs in oral hygiene. The Area Director indicated recommendations should be addressed in client plans.</p> <p>9-3-4(a)</p>		<p>not recur?</p> <ul style="list-style-type: none"> · The program director will be trained on revising goals where the criteria for completion has been met. · The program director will be trained on gaining the vocational assessments or progress at workshop · Workshop on providing vocational assessments on all clients. · A communication board will be provided for client #7. · Client #3's ISP will be updated with an objective to address his needs in tooth brushing. · Program director will ensure all communication recommendations from the speech therapist will be implemented <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 area director will review goal documentation on at least a quarterly basis · The area director will review ISPs for vocational assessments · Client #3's tooth brushing needs will be added to the MAR and formal programming to assist with tooth brushing will be implemented to ensure monitoring · Program director will ensure all communication recommendations from the 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2014	
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362			
(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			
W000255	<p>483.440(f)(1)(i) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan.</p> <p>Based on record review and interview, the facility failed to revise objectives when achieved for 4 of 4 sampled clients (clients #1, #2, #3 and #4).</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 2/20/14 at 1:45 PM. An ISP (Individual Support Plan) dated 12/10/13 included objectives to initiate coping techniques, answer medication questions, mail correspondence to family and identify coins. Client #1's record indicated he had met the criteria established at 100% accuracy. There was no evidence in the record of a revision of client #1's objectives when he met criteria.</p>	W000255	<p>speech therapists will be implemented</p> <p>5. What is the date by which the systemic changes will be completed? · March 23rd 2014</p> <p>The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary. Including but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan.</p> <p>1. What corrective action will be accomplished? · The program director will be re-trained on program monitoring and change · The goals will be reviewed/revised on a monthly basis</p> <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>	03/23/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2014	
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362			
(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>2. Client #2's record was reviewed on 2/20/14 at 12:25 PM. Client #2's ISP dated 3/12/13 included objectives to name medication and it's purpose, identify consequences of actions, make change, state/utilize ways she can cope with frustrations, clean room and change bed linens, recognize staff names, and independently complete her personal morning routine. Client #2's record indicated she had met the criteria established at 100% accuracy. There was no evidence in the record of a revision of client #2's objectives when she met criteria.</p> <p>3. Client #3's record was reviewed on 2/20/14 at 1:15 PM. Client #3's ISP dated 7/11/14 indicated objectives to clean his bedroom, independently give receipts to staff for purchases, name medication and it's purpose, independently shower, set the table for dinner, and identify the importance of not accusing peers. The record indicated he had met the criteria established at 100% accuracy. There was no evidence of a revision of client #3's objectives when he met criteria.</p> <p>4. Client #4's record was reviewed on 2/20/14 at 10:38 AM. An Individual Support Plan dated 10/24/13 indicated objectives to independently set the dial</p>		<ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice · The program director will be re-trained on program monitoring and change · The goals will be reviewed/revise on a monthly basis <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"> · The program director will be re-trained on program monitoring and change · The goals will be reviewed/revise on a monthly basis · The area director will review the goals at least quarterly to monitor for appropriate review/revision. <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 program director will review/revise the goals monthly · The area director will review the goals at least quarterly to monitor for appropriate review/revision <p>5. What is the date by which the systemic changes will be completed?</p> <ul style="list-style-type: none"> · March 23rd, 2014 				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2014	
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362			
(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>on the washer, independently brush her teeth, independently operate the dishwasher, independently cook a main dish, independently match a bill currency to the correct amount, and to independently gather items for medication administration. The record indicated she had met the criteria established at 100% accuracy. There was no evidence of a revision of client #'s objectives when she met criteria.</p> <p>The Area Director and Program Director were interviewed on 2/20/14 at 2:40 PM and indicated the clients objectives should have been revised when met.</p> <p>9-3-4(a)</p>						
W000263	<p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p>	W000263	The committee should ensure	03/23/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2014	
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362			
(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>Based on record review and interview, the facility failed to ensure informed consent was obtained for 3 of 4 sampled clients (clients #1, #2, and #3) with restrictive interventions in their plans (physical intervention, and psychotropic medication).</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 2/20/14 at 1:45 PM. A BSP (Behavior Support Plan) dated 6/27/13 indicated target behaviors of agitation, SIB (self injurious behavior), verbal aggression and physical aggression. The plan included the use of psychotropic medication and physical restraint to address behavior. Client #1's record indicated he had a guardian to assist him in making decisions. There was no evidence client #1's guardian had signed consent for his BSP.</p> <p>2. Client #2's record was reviewed on 2/20/14 at 12:25 PM. A BSP dated 2/14/14 indicated targeted behaviors of tantrums, physical aggression, property destruction, non-compliance, elopement and disruptive behavior. The plan included the use of psychotropic medication and physical restraint to address her behaviors. Client #2's record indicated she had a guardian to assist her in making decisions. There was no evidence client #2's guardian had signed consent for her BSP.</p> <p>3. Client #3's record was reviewed on 2/20/14 at 1:15 PM. Client #3's BSP dated 7/11/13 indicated target behaviors</p>		<p>that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor), or legal guardian.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · The program director will be retrained on involving the client's guardian/healthcare representative in the development of the client's BSP on 3/21/14. · Client #2's yearly ISP for 2014 was held on 2/25/14. The legal guardian was present and signed the yearly BSP signature sheet saying she was present and was involved with the BSP. <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 except two individuals who are emancipated adults · The program director will be retrained on involving the client's guardian/healthcare representative in the development of the client's BSP on 3/21/14. <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"> · The program director will 				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2014
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362		
(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	
W000312	<p>of agitation, inappropriate social skills and physical aggression. The plan included the use of psychotropic medications. Client #3's plan indicated he had a health care representative to assist him in making decisions about use of medication and restrictive interventions. There was no evidence client #3's health care representative had signed consent for his BSP.</p> <p>The Area Director and Program Director were interviewed on 2/20/14 at 2:40 PM and indicated there was no evidence of informed consent for clients #1, #2, and #3's BSPs, and the facility would be developing a plan to ensure consent was obtained.</p> <p>9-3-4(a)</p> <p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.</p>		<p>be retrained on involving the client's guardian/healthcare representative in the development of the client's BSP on 3/21/14.</p> <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur? · The program director will monitor the yearly ISP/BSP paperwork to ensure that the guardian/healthcare representative was involved in the yearly implementation of the ISP/BSP.</p> <p>5. What is the date by which the systemic changes will be completed? · March 23rd, 2014</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2014	
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362			
(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>Based on record review and interview, the facility failed to include specific criteria as part of a plan of reduction for each class of medication used for the management or elimination of behaviors and/or symptoms of diagnoses as indicated in 4 of 4 sampled clients (clients #1, #2, #3, and #4) who were prescribed medications for management of their behaviors.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 2/20/14 at 1:45 PM. A BSP (Behavior Support Plan) dated 6/27/13 indicated target behaviors of agitation, SIB (self injurious behavior, verbal aggression and physical aggression. The plan included the use of Clonidine (anxiety), Depakote (mood stabilizer), Seroquel (depression), and Trileptal (mood stabilizer). There was no evidence of which medication was targeted for which behavior, or a hierarchy of which medications were to be reduced. The plan did not indicate what specific criteria needed to be achieved to the medications to be considered for possible reductions.</p> <p>2. Client #2's record was reviewed on 2/20/14 at 12:25 PM. A BSP dated 2/14/14 indicated targeted behaviors of tantrums, physical aggression, property destruction, non-compliance, elopement and disruptive behavior. The plan included the use of Divalproex Sodium ER (extended release) for seizures and mood tantrums, Topamax for seizures and physical aggression, and</p>	W000312	<p>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.</p> <p>1. What corrective action will be accomplished? · The program director will be trained on including specific criteria for a medication reduction in the BSP as well as the need for the BSP to clearly state which medication(s) is targeted for which behavior on 3/21/14. · Revisions to client's #1, #2, #3, and #4 BSP will be completed to include specific criteria for a medication reduction as well as clearly stating which medication(s) is targeted for which behavior</p> <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? · All residents have the potential to be affected by the same deficient practice · The program director will be trained on including specific criteria for a medication reduction in the BSP as well as clearly stating which medication(s) is targeted for which behavior on 3/21/14.</p>	03/23/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2014	
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362			
(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>Invega (no dosage specified) (anti-psychotic). There was no evidence of which medication was targeted to be reduced or specific criteria needed to be achieved to the medications to be considered for possible reductions.</p> <p>3. Client #3's record was reviewed on 2/20/14 at 1:15 PM. Client #3's BSP dated 7/11/13 indicated target behaviors of agitation, inappropriate social skills and physical aggression. The plan included the use of psychotropic medications of Zyprexa (anti-psychotic), and Zoloft (antidepressant). There was no evidence of a plan for which medication was targeted to be reduced or specific criteria needed to be achieved to the medications to be considered for possible reductions.</p> <p>4. Client #4's record was reviewed on 2/20/14 at 10:38 AM. A BSP dated 10/24/13 indicated target behaviors of agitation, SIB (self injurious behavior) and AWOL (away without leave). The plan did not include the use of psychotropic medication. Physician's orders dated 3/18/14 indicated she was prescribed Ambien (sleep aid) ER (extended release 6.25 mg (milligrams) daily, Pristiq 50 mg daily (depression), and Vyvanse 70 mg daily (hyperactivity disorder). There was no evidence in the record of a plan for which medication was targeted to be reduced or specific criteria needed to be achieved to the medications to be considered for possible reductions.</p>		<ul style="list-style-type: none"> · Revisions to all client's BSP will be completed to include specific criteria for a medication reduction as well as clearly stating which medication(s) is targeted for which behavior · Area director will monitor annual ISP to ensure the BSP has specific criteria for a medication reduction and all medications clearly state which medication(s) is targeted for which behavior. <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"> · The program director will be trained on including specific criteria for a medication reduction in the BSP as well as clearly stating which medication(s) is targeted for which behavior on 3/21/14. <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · Area director will monitor annual ISP to ensure the BSP has specific criteria for a medication reduction and all medications clearly state which medication(s) is targeted for which behavior. <p>5. What is the date by which the systemic changes will be completed?</p> <ul style="list-style-type: none"> · March 23rd, 2014 				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362
---	---

(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>The Area Director and Program Director were interviewed on 2/20/14 at 2:40 PM and indicated the plans did not include specific criteria for medication reduction of client #1, #2, #3 and #4's behavior, and the plans were going to be revised to include a measurable medication reduction plan.</p> <p>9-3-5(a)</p>			