

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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
--------------------	--	---------------	---	----------------------

W 0000 Bldg. 00	<p>This visit was for the investigation of complaints #IN00175282 and #IN00185516. This visit resulted in an IMMEDIATE JEOPARDY.</p> <p>Complaint #IN00175282: Substantiated. Federal and state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W153, W154, W157 and W159.</p> <p>Complaint #IN00185516: Substantiated. Federal and state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W153, W154, W157, W159, W192, W318 and W331.</p> <p>Unrelated deficiencies are cited.</p> <p>Dates of Survey: October 26, 27, 28, 29, 30, November 2, 4, 5, 6, and 9, 2015.</p> <p>Facility number: 000869 Provider number: 15G353 AIM number: 100244230</p> <p>The following federal deficiencies also reflect state findings under 460 IAC 9. Quality Review of this report completed by #15068 on 11/17/15.</p>	W 0000		
------------------------	--	--------	--	--

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: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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
W 0102 Bldg. 00	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on record review, observation and interview, the Governing Body failed to meet the Condition of Participation: Governing Body. The Governing Body failed to provide oversight and direction to implement its policy and procedures which prohibited abuse, neglect and mistreatment for 4 of 4 sampled clients (clients A, B, C and D) and for 2 additional clients (clients E and F). The governing body failed to document falls and report them to the administrator and</p>	W 0102	<p>W 102 Governing Body The facility must ensure that specific governing body and management requirements are met.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the 	12/09/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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 BDDS (Bureau of Developmental Disabilities Services) and to investigate falls resulting in injury, hospital visits and requiring the use of emergency medical personnel to assist client C after falling. The governing body failed to develop and implement effective corrective action to protect client C from falls after a history of falls was identified. The governing body failed to ensure staff were trained to competency to protect client B from his wheelchair falling over during transport as a result of improper securing of his wheelchair, and failed to train staff competently on the health needs of 3 of 4 sampled clients (clients B, C and D). The governing body failed to ensure staff implemented identified supervision needs for client A and failed to develop and implement effective corrective action to address staff's unsafe driving habits after they had been identified in an investigation. The governing body failed to thoroughly investigate an incident involving client A being left alone and staff's unsafe driving. The governing body failed to thoroughly investigate an allegation of abuse and neglect involving clients C, E and F.</p> <p>Findings include:</p> <p>1. The governing body failed to provide oversight and direction to implement its</p>		<p>plans of clients and the client's needs are being met.</p> <ul style="list-style-type: none"> · Training completed with the staff regarding: <ul style="list-style-type: none"> o How to measure wounds o How to document skin/wound findings o Abuse, neglect and exploitation- what constitutes abuse, report expectations and investigation expectations (competency test provided) o How to document falls o When to contact the Program Coordinator o How to properly secure a wheelchair in the bus using the wheelchair tie downs for Client B o Training regarding the risk plans and health needs for Clients B, C and D. o How to monitor and document intake and elimination o How to properly cath Client D o Review the supervision needs for Client A o Staff duty sheets and cleaning expectations o Client's A-H diets o Following the menus o Use of the food substitution logs o Active treatment expectations (competency test provided) o Behavior plans and/or documentation expectations for Clients A-H o Staff approach o Vehicle use and safe driving training · The Program Coordinator and Program Director will be retrained 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>policy and procedures which prohibited abuse, neglect and mistreatment for 4 of 4 sampled clients (clients A, B, C and D) and for 4 additional clients (clients E, F, G and H). The governing body failed to document falls and report them to the administrator and to BDDS (Bureau of Developmental Disabilities Services) and to investigate falls resulting in injury, hospital visits and requiring the use of emergency medical personnel to assist client C after falling. The governing body failed to develop and implement effective corrective action to protect client C from falls after a history of falls was identified. The governing body failed to ensure staff were trained to competency to protect client B from his wheelchair falling over during transport as a result of improper securing of his wheelchair, and failed to train staff competently on the health needs of 3 of 4 sampled clients (clients B, C and D). The governing body failed to ensure staff implemented identified supervision needs for client A and failed to develop and implement effective corrective action to address staff's unsafe driving habits after they had been identified in an investigation. The governing body failed to thoroughly investigate an incident involving client A being left alone and staff's unsafe driving. The governing body failed to thoroughly investigate an allegation of abuse and</p>		<p>on the appointment process expectations, following physician recommendations and communication expectations with the nurse.</p> <ul style="list-style-type: none"> · The Program Coordinator will be trained on when to contact the Program Director. · The Program Coordinator and Program Director will be trained on reportable incidents and notifying the administrator. · The Program Coordinator and Program Director will be retrained on implementing corrective actions to address staff performance concerns and regarding recommendations made from investigations. · The Program Coordinator and Program Director will be retrained on completing environmental inspections, notifying maintenance of the maintenance needs of the home and cleaning expectations of the home. · The Program Coordinator will be trained on how to follow dietary guidelines for the residents, menus for the group home, shopping according to the menus, using the food substitution logs, and ensuring there is enough food in the home. · The Program Director will be retrained on investigation expectations and completing thorough investigations. · The Program Director will be retrained on the role and expectations of the QIDP. · The Program Director will be 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>neglect involving clients C, E and F. The governing body failed to provide oversight and direction to ensure the home was maintained in good condition and had adequate food for 4 of 4 sampled clients (clients A, B, C and D) and 4 additional clients (clients E, F, G and H). Please see W104.</p> <p>2. The governing body failed to meet the Condition of Participation: Client Protections. The governing body failed to implement its policy and procedures to prevent abuse, neglect and mistreatment for 4 of 4 sampled clients (clients A, B, C and D) and for 2 additional clients (clients E and F). The governing body failed to document falls and report them to the administrator and to BDDS (Bureau of Developmental Disabilities Services) and to investigate falls requiring the use of emergency medical personnel to assist client C after falling. The governing body failed to develop and implement effective corrective action to protect client C from falls after a history of falls was identified. The governing body failed to ensure staff were trained to competency to protect client B from his wheelchair falling over during transport as a result of improper securing of his wheelchair. The governing body failed to ensure staff implemented identified supervision needs for client A and failed</p>		<p>retrained on the IDT process.</p> <ul style="list-style-type: none"> · The Program Coordinator and Program Director will be retrained on the expectations for the medical charts. · The new nurse will be at the site weekly to help oversee the medical needs of the residents and complete assessments as needed. · The medical charts for the site have been reviewed by the nurse. · The IDT is currently meeting weekly to address Client C's health care needs. The IDT will continue to monitor his needs and may change the need to meet weekly as his health care needs improve and/or stabilize. · Client C has been participating in Physical Therapy services within the home. · Client C now has a walker, patient lift, gait belt, mat for his floor, audible monitor, motion alarm, bed rails and a wheelchair to assist in preventing falls. · Client C has had one on one supervision to assist in fall prevention. The IDT continues to monitor the need for this level of supervision to continue. The IDT will make recommendations for this supervision to change as his health care needs improve and/or stabilize. · Client C will participate in programming to help him understand the need to use his adaptive equipment and to complete his physical therapy exercises. · Client C now has a C-pap machine in place. · Client C is participating in 15 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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 develop and implement effective corrective action to address staff's unsafe driving habits after they had been identified in an investigation. The governing body failed to ensure a thorough investigation of an incident involving client A being left alone and staff's unsafe driving. Please see W122.</p> <p>3. The governing body failed to meet the Condition of Participation: Health Care Services. The governing body failed to provide oversight and direction to ensure the facility's health care services developed and implemented a system to document, monitor, and develop corrective action after a series of falls involving client C resulting in injury, hospital visits and requiring the use of emergency medical personnel to assist client C after falling. The governing body failed to provide oversight to ensure nursing services monitored to ensure staff accurately documented implementation of clients B and D risk plans to address pressure ulcers (client B) and urinary tract infections (client D) resulting in hospitalization. Please see W318.</p> <p>This federal tag relates to complaints #IN00175282 and #IN00185516.</p> <p>9-3-1(a)</p>		<p>minute checks throughout the night to monitor the use of his C-pap machine.</p> <ul style="list-style-type: none"> · Client C was seen by his psychiatrist on 10-29-15 to monitor his psych needs. He will see the psychiatrist again in January or sooner if needed. · Client C continues to see his counselor to help address his mental health needs. · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · Daily nursing oversight for Client C was completed through 11-24-15. · Currently the nurse is assessing Client C three times a week. The IDT will continue to monitor the need for this level of supervision to continue. The IDT will make recommendations for this supervision to change as his health care needs improve and/or stabilize. · Client B, C and D's risk plans will be reviewed by the nurse. Revisions will be implemented as necessary. · Program Coordinator/QIDP/nurse oversight of the MAR's, intake/elimination and skin/wound documentation (daily basis Program Coordinator) and when in the home (QIDP and nurse) to ensure it is completed and holes 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>are addressed appropriately.</p> <ul style="list-style-type: none"> · A new nurse is currently going through training. The importance of documenting her assessments accurately and ongoing will be addressed. · The nurse will be trained on how to follow up with physician recommendations to ensure they are implemented and/or addressed by the IDT. · Client D has a scheduled urology appointment on 12-21-15. · Formal programming to be implemented for Client D on reporting symptoms of a UTI. · Competency training with the nurse was completed with staff on 10-28 and 10-29-15 which included one person transfers, two person transfers, use of a gait belt, wheelchair safety, and one person assist. · Training was completed by the nurse on 10-29-15 included body mechanics/safe transfers, updated fall risk plan for Client C, adaptive equipment and change in health status reporting. · The nurse will monitor staff documentation at a minimum of weekly and communicate with the necessary team members as needed. · The nurse will conduct quarterly staff observations to ensure continued competency over adaptive equipment, body mechanics/safe transfers. · Client Specific training for new staff will include body mechanics/safe transfers and the use 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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 gait belt.</p> <ul style="list-style-type: none"> · The Program Coordinator will check adaptive equipment weekly to ensure compliance. · The living room floor rug has been removed. · The living room carpet has been cleaned. · The hole in the wall next to the medication room was repaired. · The hole in the closet door for Client's B and H will be repaired. · Client C's ISP will be updated to reflect his current needs. · The IDT will monitor trends and patterns in client reportable incidents. The IDT will convene as necessary to discuss an increase in reportable incidents such as falls. · In the event that Client B has a pressure sore, the nurse will monitor and/or assess Client B on at least a weekly basis until the sore has resolved. · Client B currently does not have a pressure sore. <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 Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met.</p> <ul style="list-style-type: none"> · Training completed with the staff regarding: <ul style="list-style-type: none"> o How to measure wounds o How to document skin/wound findings o Abuse, neglect and exploitation- what constitutes abuse, report expectations and investigation expectations (competency test provided) o How to document falls o When to contact the Program Coordinator o How to properly secure a wheelchair in the bus using the wheelchair tie downs for Client B o Training regarding the risk plans and health needs for Clients B, C and D. o How to monitor and document intake and elimination o How to properly cath Client D o Review the supervision needs for Client A o Staff duty sheets and cleaning expectations o Client's A-H diets o Following the menus o Use of the food substitution logs o Active treatment expectations (competency test provided) o Behavior plans and/or documentation expectations for Clients A-H o Staff approach o Vehicle use and safe driving training 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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
			<ul style="list-style-type: none"> · The Program Coordinator and Program Director will be retrained on the appointment process expectations, following physician recommendations and communication expectations with the nurse. · The Program Coordinator will be trained on when to contact the Program Director. · The Program Coordinator and Program Director will be trained on reportable incidents and notifying the administrator. · The Program Coordinator and Program Director will be retrained on implementing corrective actions to address staff performance concerns and regarding recommendations made from investigations. · The Program Coordinator and Program Director will be retrained on completing environmental inspections, notifying maintenance of the maintenance needs of the home and cleaning expectations of the home. · The Program Coordinator will be trained on how to follow dietary guidelines for the residents, menus for the group home, shopping according to the menus, using the food substitution logs, and ensuring there is enough food in the home. · The Program Director will be retrained on investigation expectations and completing thorough investigations. · The Program Director will be retrained on the role and expectations 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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 the QIDP.</p> <ul style="list-style-type: none"> · The Program Director will be retrained on the IDT process. · The Program Coordinator and Program Director will be retrained on the expectations for the medical charts. · The new nurse will be at the site weekly to help oversee the medical needs of the residents and complete assessments as needed. · The medical charts for the site have been reviewed by the nurse. · The IDT will continue to monitor the needs of all of the clients. The IDT will convene to address and monitor the health care needs of the residents until they improve and/or stabilize. · The need for adaptive equipment for the residents will be reviewed. In the event that additional adaptive equipment is needed the IDT will obtain it per physician recommendations. · The Program Director/QIDP will review all ISP's to ensure that they are updated and completed on a yearly basis or more frequently as the needs arise. · The Program Director/QIDP will ensure that there is formal programming in place for all residents that address identified needs. · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>workshop/day services, financial and adaptive equipment.</p> <ul style="list-style-type: none"> · All resident risk plans will be reviewed by the nurse. Revisions will be implemented as necessary. · Program Coordinator/QIDP/nurse oversight of the MAR's, intake/elimination and skin/wound documentation (daily basis Program Coordinator) and when in the home (QIDP and nurse) to ensure it is completed and holes are addressed appropriately. · A new nurse is currently going through training. The importance of documenting her assessments accurately and ongoing will be addressed. · The nurse will be trained on how to follow up with physician recommendations to ensure they are implemented and/or addressed by the IDT. · Competency training with the nurse was completed with staff on 10-28 and 10-29-15 which included one person transfers, two person transfers, use of a gait belt, wheelchair safety, and one person assist. · Training was completed by the nurse on 10-29-15 included body mechanics/safe transfers, updated fall risk plan for Client C, adaptive equipment and change in health status reporting. · The nurse will monitor staff documentation at a minimum of weekly and communicate with the necessary team members as needed. · The nurse will conduct 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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
W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review, observation and interview, the Governing Body failed to provide oversight and direction to implement its policy and procedures which prohibited abuse, neglect and mistreatment for 4 of 4 sampled clients (clients A, B, C and D) and for 4 additional clients (clients E, F, G and H). The governing body failed to document falls and report them to the administrator and to BDDS (Bureau of Developmental Disabilities Services) and to investigate falls resulting in injury, hospital visits and requiring the use of emergency</p>	W 0104	<p>quarterly staff observations to ensure continued competency over adaptive equipment, body mechanics/safe transfers.</p> <ul style="list-style-type: none"> · Client Specific training for new staff will include body mechanics/safe transfers and the use of a gait belt. · The Program Coordinator will check adaptive equipment weekly to ensure compliance. · The Program Coordinator will monitor the cleanliness of the environment daily when they are in the home. · The Program Coordinator will monitor the maintenance needs of the environment daily when they <p>W 104 Governing Body The facility must exercise general policy, budget, and operating direction over the facility.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. 	12/09/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>medical personnel to assist client C after falling. The governing body failed to develop and implement effective corrective action to protect client C from falls after a history of falls was identified. The governing body failed to ensure staff were trained to competency to protect client B from his wheelchair falling over during transport as a result of improper securing of his wheelchair, and failed to train staff competently on the health needs of 3 of 4 sampled clients (clients B, C and D). The governing body failed to ensure staff implemented identified supervision needs for client A and failed to develop and implement effective corrective action to address staff's unsafe driving habits after they had been identified in an investigation. The governing body failed to thoroughly investigate an incident involving client A being left alone and staff's unsafe driving. The governing body failed to thoroughly investigate an allegation of abuse and neglect involving clients C, E and F. The governing body failed to provide oversight and direction to ensure the home was maintained in good condition and had adequate food for 4 of 4 sampled clients (clients A, B, C and D) and 4 additional clients (clients E, F, G and H).</p> <p>Findings include:</p>		<ul style="list-style-type: none"> · Training completed with the staff regarding: <ul style="list-style-type: none"> o How to measure wounds o How to document skin/wound findings o Abuse, neglect and exploitation- what constitutes abuse, report expectations and investigation expectations (competency test provided) o How to document falls o When to contact the Program Coordinator o How to properly secure a wheelchair in the bus using the wheelchair tie downs for Client B o Training regarding the risk plans and health needs for Clients B, C and D. o How to monitor and document intake and elimination o How to properly cath Client D o Review the supervision needs for Client A o Staff duty sheets and cleaning expectations o Client's A-H diets o Following the menus o Use of the food substitution logs o Active treatment expectations (competency test provided) o Behavior plans and/or documentation expectations for Clients A-H o Staff approach o Vehicle use and safe driving training · The Program Coordinator and Program Director will be retrained on the appointment process expectations, following physician 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>1. Observations were completed at the group home on 10/26/15 from 5:55 PM until 7:06 PM. The rug on the floor in the living room had 28 stains ranging in size from 1 " (inch) in diameter to 4 and 1/2 inches by 6 inches by 2 inches (irregular shaped). There was a hole in the wall 3 and 1/2 inches by 3 inches next to the medication room used by clients A, B, C, D, E, F, G and H. There was a hole in the closet door of clients B and H ' s bedroom closet.</p> <p>Staff #3 was interviewed on 10/26/15 at 6:15 PM and stated the hole in the wall had been made by client G who had hit the wall " about 6 weeks ago. "</p> <p>The PC (Program Coordinator) was interviewed on 10/26/15 at 6:10 PM and indicated he had just started working at the home last week and he was uncertain of the status of the repairs, or of the status of plans to address the condition of the rug.</p> <p>2. Observations at the group home were completed on 10/27/15 from 7:10 AM until 8:38 AM. Client C ate a cinnamon roll and beverage. No other food items were offered for the breakfast meal. An uneaten partial pan of rolls was on the kitchen counter.</p>		<p>recommendations and communication expectations with the nurse.</p> <ul style="list-style-type: none"> · The Program Coordinator will be trained on when to contact the Program Director. · The Program Coordinator and Program Director will be trained on reportable incidents and notifying the administrator. · The Program Coordinator and Program Director will be trained on reporting incidents to the administrator timely. · The Program Coordinator and Program Director will be retrained on implementing corrective actions to address staff performance concerns and regarding recommendations made from investigations. · The Program Coordinator and Program Director will be retrained on completing environmental inspections, notifying maintenance of the maintenance needs of the home and cleaning expectations of the home. · The Program Coordinator will be trained on how to follow dietary guidelines for the residents, menus for the group home, shopping according to the menus, using the food substitution logs, and ensuring there is enough food in the home. · The Program Director will be retrained on investigation expectations and completing thorough investigations. · The Program Director will be retrained on the role and expectations 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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 menu for the week dated week 3 fall/winter menu was reviewed on 10/27/15 at 8:00 AM and indicated 3/4 cup of apple juice, 3/4 cup of whole grain cereal or 1/2 cup of cereal of choice, 2 slices of whole wheat toast, 1 tsp (teaspoon) of margarine, 1 boiled egg, 1 cup of water, coffee/tea as desired and 1 cup of skim milk or 1/2 % milk.</p> <p>Staff #4 was interviewed on 10/27/15 at 8:05 AM and indicated there was no food in the house listed on the menu except cereal and stated, "They had that yesterday." She indicated clients A, B, D, E, F, G and H had already eaten their breakfast of cinnamon rolls.</p> <p>The contents of the refrigerator, freezer and pantry shelves were observed on 10/27/15 at 8:05 AM and indicated there were 8 eggs, 2 containers of biscuits, 1 inch remaining in a gallon of milk, 2 containers of buttermilk biscuits, 3 cans of frozen fruit punch, 3 plastic containers of cereal, 7 potatoes, 3 onions, and 1 zip closed 1 pound plastic container of sliced frozen chicken meat.</p> <p>The Program Director was interviewed on 10/29/15 at 7:30 AM. When asked about adequate food in the home, he indicated there should be adequate food and he supplied the staff with funds to</p>		<p>of the QIDP.</p> <ul style="list-style-type: none"> · The Program Director will be retrained on the IDT process. · The Program Coordinator and Program Director will be retrained on the expectations for the medical charts. · The new nurse will be at the site weekly to help oversee the medical needs of the residents and complete assessments as needed. · The medical charts for the site have been reviewed by the nurse. · The IDT is currently meeting weekly to address Client C's health care needs. The IDT will continue to monitor his needs and may change the need to meet weekly as his health care needs improve and/or stabilize. · Client C has been participating in Physical Therapy services within the home. · Client C now has a walker, patient lift, gait belt, mat for his floor, audible monitor, motion alarm, bed rails and a wheelchair to assist in preventing falls. · Client C has had one on one supervision to assist in fall prevention. The IDT continues to monitor the need for this level of supervision to continue. The IDT will make recommendations for this supervision to change as his health care needs improve and/or stabilize. · Client C will participate in programming to help him understand the need to use his adaptive equipment and to complete his physical therapy exercises. · Client C now has a C-pap 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>purchase enough food.</p> <p>3. The Governing Body failed to provide oversight and direction to implement its policy and procedures which prohibited abuse, neglect and mistreatment for 4 of 4 sampled clients (clients A, B, C and D) and 2 additional clients (clients E and F). The governing body failed to document falls and report them to the administrator and to BDDS (Bureau of Developmental Disabilities Services) and to investigate falls resulting in injury, hospital visits and requiring the use of emergency medical personnel to assist client C after falling. The governing body failed to develop and implement effective corrective action to protect client C from falls after a history of falls was identified. The governing body failed to ensure staff were trained to competency to protect client B from his wheelchair falling over during transport as a result of improper securing of his wheelchair. The governing body failed to ensure staff implemented identified supervision needs for client A and failed to develop and implement effective corrective action to address staff's unsafe driving habits after they had been identified in an investigation. The governing body failed to thoroughly investigate an incident involving client A being left alone and staff's unsafe driving. The governing</p>		<p>machine in place.</p> <ul style="list-style-type: none"> · Client C is participating in 15 minute checks throughout the night to monitor the use of his C-pap machine. · Client C was seen by his psychiatrist on 10-29-15 to monitor his psych needs. He will see the psychiatrist again in January or sooner if needed. · Client C continues to see his counselor to help address his mental health needs. · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · Daily nursing oversight for Client C was completed through 11-24-15. · Currently the nurse is assessing Client C three times a week. The IDT will continue to monitor the need for this level of supervision to continue. The IDT will make recommendations for this supervision to change as his health care needs improve and/or stabilize. · Client B, C and D's risk plans will be reviewed by the nurse. Revisions will be implemented as necessary. · Program Coordinator/QIDP/nurse oversight of the MAR's, intake/elimination and skin/wound documentation (daily basis Program Coordinator) and 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>body failed to thoroughly investigate an allegation of abuse and neglect involving clients C, E and F. Please see W149.</p> <p>4. The governing body failed for 2 of 4 sampled clients (clients B and C), to document falls and report them to the administrator and to BDDS (Bureau of Developmental Disabilities Services) in accordance to state law. Please see W153.</p> <p>5. The governing body failed for 2 of 2 sampled clients (clients B and C) to thoroughly investigate falls involving clients B and C. The governing body failed to thoroughly investigate an incident involving client A being left alone and staff's unsafe driving. The governing body failed to thoroughly investigate an allegation of abuse and neglect involving clients C, E and F. Please see W154.</p> <p>6. The governing body failed for 2 of 4 sampled clients (clients B and C) to develop and implement effective corrective action to protect client C from falls after a history of falls was identified. The governing body failed to protect client B from his wheelchair falling over during transport as a result of improper securing of his wheelchair, and failed to provide supervision and protect client A</p>		<p>when in the home (QIDP and nurse) to ensure it is completed and holes are addressed appropriately.</p> <ul style="list-style-type: none"> · A new nurse is currently going through training. The importance of documenting her assessments accurately and ongoing will be addressed. · The nurse will be trained on how to follow up with physician recommendations to ensure they are implemented and/or addressed by the IDT. · Client D has a scheduled urology appointment on 12-21-15. · Formal programming to be implemented for Client D on reporting symptoms of a UTI. · Competency training with the nurse was completed with staff on 10-28 and 10-29-15 which included one person transfers, two person transfers, use of a gait belt, wheelchair safety, and one person assist. · Training was completed by the nurse on 10-29-15 included body mechanics/safe transfers, updated fall risk plan for Client C, adaptive equipment and change in health status reporting. · The nurse will monitor staff documentation at a minimum of weekly and communicate with the necessary team members as needed. · The nurse will conduct quarterly staff observations to ensure continued competency over adaptive equipment, body mechanics/safe transfers. · Client Specific training for 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>from impaired/unsafe driving by the same staff who failed to secure the wheelchair properly. The governing body failed to implement effective corrective action to address the staff's unsafe driving habits after they had been identified in an investigation. Please see W157.</p> <p>7. The governing body failed to train staff competently on the behavioral needs of 1 additional client (client F). Please see W191.</p> <p>8. The governing body failed to train staff competently on the health needs of 3 of 4 sampled clients (clients B, C and D). Please see W192.</p> <p>9. The governing body failed to provide oversight to ensure the facility's health care services developed and implemented a system to document, monitor, and address client C's changing health care needs after a series of falls involving client C resulting in injury, hospital visits and requiring the use of emergency medical personnel to assist client C after falling. The governing body failed to ensure the facility's nursing services provided monitoring to ensure staff accurately documented implementation of clients B and D risk plans to address pressure ulcers (client B) and urinary tract infections (client D) resulting in</p>		<p>new staff will include body mechanics/safe transfers and the use of a gait belt.</p> <ul style="list-style-type: none"> · The Program Coordinator will check adaptive equipment weekly to ensure compliance. · The living room floor rug has been removed. · The living room carpet has been cleaned. · The hole in the wall next to the medication room was repaired. · The hole in the closet door for Client's B and H will be repaired. · Client C's ISP will be updated to reflect his current needs. · The IDT will monitor trends and patterns in client reportable incidents. The IDT will convene as necessary to discuss an increase in reportable incidents such as falls. · In the event that Client B has a pressure sore, the nurse will monitor and/or assess Client B on at least a weekly basis until the sore has resolved. · Client B currently does not have a pressure sore. · Staff 4 was trained by the Behavior Clinician on 11-4-15 on Client F's behavior plan. <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 Coordinator will 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/09/2015
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012		
(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>hospitalization. Please see W331.</p> <p>This federal tag relates to complaints #IN00175282 and #IN00185516.</p> <p>9-3-1(a)</p>		<p>do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met.</p> <ul style="list-style-type: none"> · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: <ul style="list-style-type: none"> o How to measure wounds o How to document skin/wound findings o Abuse, neglect and exploitation-what constitutes abuse, report expectations and investigation expectations (competency test provided) o How to document falls o When to contact the Program Coordinator o How to properly secure a wheelchair in the bus using the wheelchair tie downs for Client B o Training regarding the risk plans and health needs for Clients B, C and D. o How to monitor and document intake and elimination o How to properly cath Client D o Review the supervision needs for Client A o Staff duty sheets and cleaning expectations o Client's A-H diets o Following the menus o Use of the food substitution logs o Active treatment expectations (competency test provided) o Behavior plans and/or 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>documentation expectations for Clients A-H</p> <ul style="list-style-type: none"> o Staff approach o Vehicle use and safe driving training <ul style="list-style-type: none"> · The Program Coordinator and Program Director will be retrained on the appointment process expectations, following physician recommendations and communication expectations with the nurse. · The Program Coordinator will be trained on when to contact the Program Director. · The Program Coordinator and Program Director will be trained on reporting incidents to the administrator timely. · The Program Coordinator and Program Director will be trained on reportable incidents and notifying the administrator. · The Program Coordinator and Program Director will be retrained on implementing corrective actions to address staff performance concerns and regarding recommendations made from investigations. · The Program Coordinator and Program Director will be retrained on completing environmental inspections, notifying maintenance of the maintenance needs of the home and cleaning expectations of the home. · The Program Coordinator will be trained on how to follow dietary guidelines for the residents, menus for the group home, shopping 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>according to the menus, using the food substitution logs, and ensuring there is enough food in the home.</p> <ul style="list-style-type: none"> · The Program Director will be retrained on investigation expectations and completing thorough investigations. · The Program Director will be retrained on the role and expectations of the QIDP. · The Program Director will be retrained on the IDT process. · The Program Coordinator and Program Director will be retrained on the expectations for the medical charts. · The new nurse will be at the site weekly to help oversee the medical needs of the residents and complete assessments as needed. · The medical charts for the site have been reviewed by the nurse. · The IDT will continue to monitor the needs of all of the clients. The IDT will convene to address and monitor the health care needs of the residents until they improve and/or stabilize. · The need for adaptive equipment for the residents will be reviewed. In the event that additional adaptive equipment is needed the IDT will obtain it per physician recommendations. · The Program Director/QIDP will review all ISP's to ensure that they are updated and completed on a yearly basis or more frequently as the needs arise. · The Program Director/QIDP will ensure that there is formal 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>programming in place for all residents that address identified needs.</p> <ul style="list-style-type: none"> · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · All resident risk plans will be reviewed by the nurse. Revisions will be implemented as necessary. · Program Coordinator/QIDP/nurse oversight of the MAR's, intake/elimination and skin/wound documentation (daily basis Program Coordinator) and when in the home (QIDP and nurse) to ensure it is completed and holes are addressed appropriately. · A new nurse is currently going through training. The importance of documenting her assessments accurately and ongoing will be addressed. · The nurse will be trained on how to follow up with physician recommendations to ensure they are implemented and/or addressed by the IDT. · Competency training with the nurse was completed with staff on 10-28 and 10-29-15 which included one person transfers, two person transfers, use of a gait belt, wheelchair safety, and one person assist. · Training was completed by the nurse on 10-29-15 included body 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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
W 0122 Bldg. 00	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based upon observation, record review, and interview, the facility failed to meet the Condition of Participation: Client Protections. The facility failed to implement its policy and procedures to prevent abuse, neglect and mistreatment for 4 of 4 sampled clients (clients A, B, C and D) and for 2 additional clients (clients E and F). The facility failed to document falls for client C, report them to the administrator and to BDDS (Bureau of Developmental Disabilities Services) and to investigate falls requiring the use of emergency medical personnel to assist client C after falling. The facility failed to develop and	W 0122	mechanics/safe transfers, updated fall risk plan for Client C, adaptive equipment and change in health status reporting. · The nurse will monitor staff documentation at a minimum of weekly and communicate with the necessary team members as needed. · The nurse will conduct quarterly staff observations to ensure continued competency over adaptive equipment, body mechanics/safe transfers. · Client Specific training for new staff will include body mechanics/safe transfers and the use of a gait belt. W 122 Client Protections The facility must ensure that specific client protections requirements are met. 1. What corrective action will be accomplished? · The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding:	12/09/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>implement effective corrective action to protect client C from falls after a history of falls was identified.</p> <p>This noncompliance resulted in an IMMEDIATE JEOPARDY. The IMMEDIATE JEOPARDY began on 10/7/15. The Immediate Jeopardy was identified on 10/28/15 at 12:55 PM. The Area Director, Regional Director, Program Director, Behavioral Services Clinician, Program Coordinator and Registered Nurse were notified of the Immediate Jeopardy on 10/28/15 at 4:55 PM.</p> <p>A plan of action from the facility to remove the immediate jeopardy, dated 10/29/15 was received on 10/29/15 at 6:20 PM. The plan indicated the following steps would be immediately implemented:</p> <p>"The following actions and protective measures are in place or are in process to abate the immediate jeopardy in regards to the noted failure to identify, develop and implement effective corrective action to prevent falls at Parkway. 10.28.15 -[Nurse], LPN (licensed practical nurse) provided body mechanics training to</p>		<ul style="list-style-type: none"> o Abuse, neglect and exploitation-what constitutes abuse, report expectations and investigation expectations (competency test provided) o How to document falls o When to contact the Program Coordinator o How to properly secure a wheelchair in the bus using the wheelchair tie downs for Client B o Training regarding the risk plans and health needs for Clients B, C and D. o Behavior plans and/or documentation expectations for Clients A-H o Staff approach o Vehicle use and safe driving training <ul style="list-style-type: none"> · The Program Coordinator and Program Director will be retrained on the appointment process expectations, following physician recommendations and communication expectations with the nurse. · The Program Coordinator will be trained on when to contact the Program Director. · The Program Coordinator and Program Director will be trained on reportable incidents and notifying the administrator. · The Program Coordinator and Program Director will be trained on reporting incidents to the administrator timely. · The Program Coordinator and Program Director will be retrained on implementing corrective actions 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 11/09/2015	
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012			
(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>current on-duty staff. These staff successfully participated in repeat skills demonstration with this nurse which included one person transfer, two person transfer, use of gait belt, wheel chair safety, and one person assist.</p> <p>-1:1 one to one staff support was implemented to reduce the risk of this client falling.</p> <p>-[Nurse #1], LPN completed a nursing assessment on this client during the evening of 10.28.15 in his home.</p> <p>-[Nurse #2], LPN completed a nursing assessment on this client during the morning of 10.28.15 in his home.</p> <p>-Communication was attempted (2 calls and 1 fax) with [Doctor] (PCP) (Primary Care Physician) by [Name of RN], RN (registered nurse).</p> <p>-Human Rights approval was obtained for the following restrictions:</p> <ul style="list-style-type: none"> -Bell to signal staff for his request to ambulate and/or transfer -Audible Personal monitor placed next to his bed to ensure safety -Personal weight sensitive alarm used in his bed or chair to signal staff should he attempt ambulation without assistance from either place. 		<p>to address staff performance concerns and regarding recommendations made from investigations.</p> <ul style="list-style-type: none"> · The Program Coordinator and Program Director will be retrained on completing environmental inspections, notifying maintenance of the maintenance needs of the home and cleaning expectations of the home. · The Program Director will be retrained on investigation expectations and completing thorough investigations. · The Program Director will be retrained on the role and expectations of the QIDP. · The Program Director will be retrained on the IDT process. · The new nurse will be at the site weekly to help oversee the medical needs of the residents and complete assessments as needed. · The IDT is currently meeting weekly to address Client C's health care needs. The IDT will continue to monitor his needs and may change the need to meet weekly as his health care needs improve and/or stabilize. · Client C has been participating in Physical Therapy services within the home. · Client C now has a walker, patient lift, gait belt, mat for his floor, audible monitor, motion alarm, bed rails and a wheelchair to assist in preventing falls. · Client C has had one on one supervision to assist in fall prevention. The IDT continues to 				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>-Mat on the floor next to his bed for safety</p> <p>-Physician order for mechanical lift to assist with safe transfers as needed</p> <p>-Half bed rail to reduce the risk of this client falling from his bed and to assist with independent repositioning while in his bed</p> <p>-Gait belt to ensure safe ambulation to decrease the risk of falls</p> <p>-Use of the wheelchair at all times to ensure safe ambulation</p> <p>-IDT (interdisciplinary team meeting) was held to discuss the needs of this client with regards to recent falls and subsequent requests for lift assistance from the local fire department. 10.29.15</p> <p>-[Nurse #1], LPN provided body mechanics training to an oncoming staff the morning of 10.29.15. These staff successfully participated in repeat skills demonstration with this nurse which included one person transfer, two person transfer, use of gait belt, wheel chair safety, and one person assist.</p> <p>-[Nurse #2], LPN provided a nursing assessment of this client while in his home.</p>		<p>monitor the need for this level of supervision to continue. The IDT will make recommendations for this supervision to change as his health care needs improve and/or stabilize.</p> <ul style="list-style-type: none"> · Client C will participate in programming to help him understand the need to use his adaptive equipment and to complete his physical therapy exercises. · Client C now has a C-pap machine in place. · Client C is participating in 15 minute checks throughout the night to monitor the use of his C-pap machine. · Client C was seen by his psychiatrist on 10-29-15 to monitor his psych needs. He will see the psychiatrist again in January or sooner if needed. · Client C continues to see his counselor to help address his mental health needs. · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · Daily nursing oversight for Client C was completed through 11-24-15. · Currently the nurse is assessing Client C three times a week. The IDT will continue to monitor the need for this level of supervision to continue. The IDT will make recommendations for this 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>-[Nurse #1], LPN observed this client in his home during a visit this morning.</p> <p>-[Name of RN], RN provided staff training for the group home staff. Training included the following topics: body mechanics/safe transfers, gait belt use, mechanical lift use, updated fall risk plan, adaptive equipment, and change in health status reporting.</p> <p>-The home staff successfully participated in repeat skills demonstration with the nurses which included one person transfer, two person transfer, use of gait belt, wheel chair safety, one person assist, use of a mechanical lift and use of slide board.</p> <p>-A new mechanical lift was delivered to the home.</p> <p>-The non-skid mat was placed beside his bed.</p> <p>-The half bed rail was installed on his bed.</p> <p>-The personal alarm was provided to him. He chose to maintain possession.</p> <p>-A bell was secured to his wheelchair.</p> <p>-An IDT was held with this client to discuss his current safety needs as related to recent falls and supports</p>		<p>supervision to change as his health care needs improve and/or stabilize.</p> <ul style="list-style-type: none"> · Client B, C and D's risk plans will be reviewed by the nurse. Revisions will be implemented as necessary. · Program Coordinator/QIDP/nurse oversight of the MAR's, intake/elimination and skin/wound documentation (daily basis Program Coordinator) and when in the home (QIDP and nurse) to ensure it is completed and holes are addressed appropriately. · The nurse will be trained on how to follow up with physician recommendations to ensure they are implemented and/or addressed by the IDT. · Competency training with the nurse was completed with staff on 10-28 and 10-29-15 which included one person transfers, two person transfers, use of a gait belt, wheelchair safety, and one person assist. · Training was completed by the nurse on 10-29-15 included body mechanics/safe transfers, updated fall risk plan for Client C, adaptive equipment and change in health status reporting. · The nurse will monitor staff documentation at a minimum of weekly and communicate with the necessary team members as needed. · The nurse will conduct quarterly staff observations to ensure continued competency over adaptive equipment, body mechanics/safe transfers. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>implemented to ensure his general safety.</p> <p>-Formal training was implemented with this client to increase his independence with general safety.</p> <p>-[Name], RN received (sic) return call from [PCP name] office regarding the needs of this client. The doctor is currently out of the office on this day but the nurse reported she would communicate any requests to him and respond accordingly.</p> <p>-[Name], RN had phone communication with [hospital home health PT (physical therapy) to follow up on their assessment completed on 10.28.15.</p> <p>-This client attended his psychiatric appointment as scheduled on this day. No changes noted.</p> <p>-The Behavioral Support Plan has been revised to reflect the restrictions as noted above.</p> <p>The following actions, protective measures and monitoring will be implemented moving forward.</p> <p>-Facility nurse will provide daily observations of this client and communicate with necessary team members as needed.</p>		<ul style="list-style-type: none"> · Client Specific training for new staff will include body mechanics/safe transfers and the use of a gait belt. · The Program Coordinator will check adaptive equipment weekly to ensure compliance. · The IDT will monitor trends and patterns in client reportable incidents. The IDT will convene as necessary to discuss an increase in reportable incidents such as falls. · Staff 4 was trained by the Behavior Clinician on 11-4-15 on Client F's behavior plan. <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 Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: <ul style="list-style-type: none"> ○ Abuse, neglect and exploitation- what constitutes abuse, report expectations and investigation expectations (competency test provided) 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>-Facility nurse will monitor staff documentation at minimum weekly and communicate with necessary team members as needed.</p> <p>-Staff training will be provided on procedures for reporting of incidents on Monday 11.2.15.</p> <p>-Facility nurse will conduct quarterly staff observations to ensure continued competency over adaptive equipment, body mechanics/safe transfers.</p> <p>-Continue with Physical Therapy recommendations.</p> <p>-Follow up with recent sleep study results and any subsequent recommendations.</p> <p>-The IDT will convene to discuss any identified health related needs as needed.</p> <p>-Client specific training for new staff will include body mechanics training/safe transfers and the use of a gait belt.</p> <p>-The Program Coordinator will check adaptive equipment weekly to ensure compliance."</p> <p>On 10/29/15 from 6:30 AM until 8:30 AM, upon arrival at the group home, client C was asleep in his bed. When client C needed to use the restroom, nurse #1 demonstrated how to assist client C in</p>		<ul style="list-style-type: none"> o How to document falls o When to contact the Program Coordinator o How to properly secure a wheelchair in the bus using the wheelchair tie downs for Client B o Training regarding the risk plans and health needs for Clients B, C and D. o Behavior plans and/or documentation expectations for Clients A-H o Staff approach o Vehicle use and safe driving training <ul style="list-style-type: none"> · The Program Coordinator and Program Director will be retrained on the appointment process expectations, following physician recommendations and communication expectations with the nurse. · The Program Coordinator will be trained on when to contact the Program Director. · The Program Coordinator and Program Director will be trained on reporting incidents to the administrator timely. · The Program Coordinator and Program Director will be trained on reportable incidents and notifying the administrator. · The Program Coordinator and Program Director will be retrained on implementing corrective actions to address staff performance concerns and regarding recommendations made from investigations. · The Program Director will be 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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
	transferring from his bed to a wheelchair while staff #12 and #13 observed. The nurse demonstrated positioning of herself, the wheelchair and client C to assist him to transfer and using the gait belt to assist client C including proper placement and tension of the gait belt. Nurse #1 indicated while instructing staff #12 and #13 client C was to have 1:1 staff supervision at the present time for safety to prevent falls and to assist client C as necessary to provide safety, but to allow client C to do as much as he was able to do for himself independently during transfers. During the demonstration, staff #13 indicated she was unaware client C required assistance to transfer and had allowed him to transfer independently earlier on her shift. Client C was then pushed in his wheelchair to the toilet and nurse #1 indicated staff #12 and #13 would be assisting client C to transfer in the restroom using techniques demonstrated by nurse #1. Staff #12 and #13 then went with nurse #1 and client C to the restroom. During the observation, client C had a wheelchair next to his bed, a half bedrail on his bed, a mat on the floor, an audible alarm that sounded when he raised his body from the bed and a bell on his wheelchair. The PD (Program Director) #1 was present in the home as staff #4 cooked breakfast, and nurse #1		retrained on investigation expectations and completing thorough investigations. <ul style="list-style-type: none"> · The Program Director will be retrained on the role and expectations of the QIDP. · The Program Director will be retrained on the IDT process. · The new nurse will be at the site weekly to help oversee the medical needs of the residents and complete assessments as needed. · The medical charts for the site have been reviewed by the nurse. · The IDT will continue to monitor the needs of all of the clients. The IDT will convene to address and monitor the health care needs of the residents until they improve and/or stabilize. · The need for adaptive equipment for the residents will be reviewed. In the event that additional adaptive equipment is needed the IDT will obtain it per physician recommendations. · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · All resident risk plans will be reviewed by the nurse. Revisions will be implemented as necessary. · Program Coordinator/QIDP/nurse oversight of the MAR's, intake/elimination and skin/wound documentation (daily 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>trained staff #12 and #13.</p> <p>Nurse #1 was interviewed on 10/29/15 at 7:00 AM and indicated she had provided training to staff on the evening shift on 10/28/15 and would continue training that day with staff on body mechanics of assisting client C to transfer and using the gait belt to assist client C.</p> <p>Observations were completed at the group home on 10/29/15 from 7:01 PM until 8:00 PM. PC (Program Coordinator) #2 and PD #2 were present in the home at the beginning of the observation. PD #2 and PC #2 both stated they were in the home to provide "extra support." Staff #3 and #14 assisted client C to his wheelchair to use the restroom and back into bed using transfer techniques demonstrated by nurse #1. The alarm next to client C's bed sounded as he raised from the bed, 1 staff stayed with client C at all times during the observation, client C's wheelchair had a bell attached to the side of his arm rests, and a floor mat was next to his bed. A hoyer lift (mechanical lift to assist in raising and lowering a person) was in the common office of the group home. Staff #10 was in the home assisting other clients.</p> <p>PC #2 was interviewed on 10/29/15 at</p>		<p>basis Program Coordinator) and when in the home (QIDP and nurse) to ensure it is completed and holes are addressed appropriately.</p> <ul style="list-style-type: none"> · The nurse will be trained on how to follow up with physician recommendations to ensure they are implemented and/or addressed by the IDT. · Competency training with the nurse was completed with staff on 10-28 and 10-29-15 which included one person transfers, two person transfers, use of a gait belt, wheelchair safety, and one person assist. · Training was completed by the nurse on 10-29-15 included body mechanics/safe transfers, updated fall risk plan for Client C, adaptive equipment and change in health status reporting. · The nurse will monitor staff documentation at a minimum of weekly and communicate with the necessary team members as needed. · The nurse will conduct quarterly staff observations to ensure continued competency over adaptive equipment, body mechanics/safe transfers. · Client Specific training for new staff will include body mechanics/safe transfers and the use of a gait belt. · The Program Coordinator will check adaptive equipment weekly to ensure compliance. · The IDT will monitor trends and patterns in client reportable incidents. The IDT will convene as 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>7:35 PM and indicated there would now be 3 staff in the home to ensure client C had 1:1 staff coverage. PC #2 stated he "came by (the group home) to make sure everything is going OK."</p> <p>Staff #14 was interviewed on 10/29/15 at 7:01 PM and indicated she had been trained on client C's risk plan, safe transfers, using the hoyer lift, slide board and gait belt to assist client C.</p> <p>Staff #3 was interviewed on 10/29/15 at 7:06 PM and indicated he had received training on client C's risk plan, safe transfers, using the hoyer lift, slide board and gait belt to assist client C.</p> <p>Staff #10 was interviewed on 10/29/15 at 7:40 PM and indicated she had been trained on client C's risk plan, safe transfers, using the hoyer lift, slide board and gait belt to assist client C.</p> <p>T-Log notes by group home nurse #1, #2 and the RN were reviewed on 10/30/15 at 1:26 PM and indicated the following:</p> <p>A note dated 10/28/15 at 2:51 PM written by nurse #2 indicated client C was sleeping upon arrival of the nurse. Staff #12 was at client C's side during the nursing assessment. Client C "was independent in undressing and</p>		<p>necessary to discuss an increase in reportable incidents such as falls.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: <ul style="list-style-type: none"> o Abuse, neglect and exploitation-what constitutes abuse, report expectations and investigation expectations (competency test provided) o How to document falls o When to contact the Program Coordinator o How to properly secure a wheelchair in the bus using the wheelchair tie downs for Client B o Training regarding the risk plans and health needs for Clients B, C and D. o Behavior plans and/or documentation expectations for Clients A-H o Staff approach o Vehicle use and safe driving training · The Program Coordinator and 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 11/09/2015
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012		
(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>transferring to his wc (wheelchair)...was alert and answered all of my questions. Bilateral discoloration noted in both legs. Per staff member, this is nothing new and has improved. Staff also commented that [client C] was more alert and mobile than he has been recently. No apparent medical concerns noted during my visit."</p> <p>A note dated 10/28/15 at 3:08 PM written by the RN indicated the RN had left a voice mail message for client C's PCP requesting an appointment for client C and to discuss the results of a sleep study-need for order for CPAP (continuous positive airway pressure) or referral to [Dr.]...." The nurse indicated she had faxed client C's PCP's office with a copy of client C's sleep study and a request for the CPAP machine and an appointment. "I did advise [PCP] in the fax that [client C] would receive home PT eval and treat starting today, requested order for wheelchair and gait belt as well due to unsteady gait and increase in falls. I have directed at this point to utilize wheelchair and gait belt for safety purposes...."</p> <p>A note dated 10/28/15 at 10:30 PM written by nurse #1 indicated client C was "in a good mood color slightly pale...I trained staff on the use of a gait belt and one man assist transfer from</p>		<p>Program Director will be retrained on the appointment process expectations, following physician recommendations and communication expectations with the nurse.</p> <ul style="list-style-type: none"> · The Program Coordinator will be trained on when to contact the Program Director. · The Program Coordinator and Program Director will be trained on reporting incidents to the administrator timely. · The Program Coordinator and Program Director will be trained on reportable incidents and notifying the administrator. · The Program Coordinator and Program Director will be retrained on implementing corrective actions to address staff performance concerns and regarding recommendations made from investigations. · The Program Director will be retrained on investigation expectations and completing thorough investigations. · The Program Director will be retrained on the role and expectations of the QIDP. · The Program Director will be retrained on the IDT process. · The new nurse will be at the site weekly to help oversee the medical needs of the residents and complete assessments as needed. · The medical charts for the site have been reviewed by the nurse. · The IDT will continue to monitor the needs of all of the 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 11/09/2015	
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012			
(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>wheelchair to chair and than (sic) a two man assist (sic) we also did this in the bathroom from wheelchair to toilet one and two man. By this time [client C] was getting tired so we did a one man assist to bed. All staff did hands on training with [client C] and transfers. I than trained on one man and two man assist walking using other staff members."</p> <p>A note dated 10/29/15 at 4:32 PM and reported on at 6:30 AM written by nurse #1 indicated "Went to see [client C] today at his home and he was still in bed, I woke him up and asked him how he was and he said that he was okay and wanted a shower. I told him he was going to get a shower and that we were going to train a couple of the staff with him through his shower and he said okay. Trained on transfers one and two man from bed to chair than chair to toilet than toilet to shower chair than back to wheelchair. I thanked [client C] and told him that he did a great job and that i (sic) was glad he was doing so well."</p> <p>A note dated 10/29/15 at 3:57 PM written by nurse #2 indicated "In [client C's] home today at 9:20 a.m. When I arrived [client C] was lying in bed asleep. He had been assisted with a shower and dressed for the day. 1:1 staff present. [Client C] was sleeping comfortably...." The nurse</p>		<p>clients. The IDT will convene to address and monitor the health care needs of the residents until they improve and/or stabilize.</p> <ul style="list-style-type: none"> The need for adaptive equipment for the residents will be reviewed. In the event that additional adaptive equipment is needed the IDT will obtain it per physician recommendations. The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. All resident risk plans will be reviewed by the nurse. Revisions will be implemented as necessary. Program Coordinator/QIDP/nurse oversight of the MAR's, intake/elimination and skin/wound documentation (daily basis Program Coordinator) and when in the home (QIDP and nurse) to ensure it is completed and holes are addressed appropriately. The nurse will be trained on how to follow up with physician recommendations to ensure they are implemented and/or addressed by the IDT. Competency training with the nurse was completed with staff on 10-28 and 10-29-15 which included one person transfers, two person transfers, use of a gait belt, wheelchair safety, and one person assist. 				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>completed an assessment of client C's vital signs and indicated in the note, "After my assessment [client C] stated that he needed to use the RR (restroom). He was assisted to his wc with gait belt in place. [Client C] cooperated well with transfer. Assisted with transfer. He was then assisted to the RR. Shortly after he left the home to attend an appointment."</p> <p>A note dated 10/30/15 at 9:54 AM written by the RN indicated client C was asleep upon her arrival, but the staff informed her client C had been up and had just fallen back to sleep. "I was able to easily arouse [client C] to determine his oriented at baseline...I did discussed (sic) with [client C] concern regarding his safety and why nurses are monitoring him closely. Later [client C] was up while I was at the home, he transferred without difficult (sic) with assist of one staff, gait belt on, he has eyes closed often but clearly is aware of the conversation as he responds appropriately and interactively. I also did discuss his recent sleep study results and explained his sleep apnea and need for CPAP." The note indicated client C left for an appointment with his psychiatric care provider and later returned to the group home and went to his room. "I was training staff in the home and heard [client C] yelling 'I want my porn,' I ask (sic) [client C] if he</p>		<ul style="list-style-type: none"> · Training was completed by the nurse on 10-29-15 included body mechanics/safe transfers, updated fall risk plan for Client C, adaptive equipment and change in health status reporting. · The nurse will monitor staff documentation at a minimum of weekly and communicate with the necessary team members as needed. · The nurse will conduct quarterly staff observations to ensure continued competency over adaptive equipment, body mechanics/safe transfers. · Client Specific training for new staff will include body mechanics/safe transfers and the us 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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
	discussed with his psych today and he reports that 'She said I have to talk to [AD].' I responded and advised, 'ok [client C], I will talk to [AD] and see about scheduling a meeting with the team to discuss as fast as we can.' Initially [client C] responded 'ok' but then approximately 2 minutes later he again began yelling. I requested staff get [AD] who was present in the home as well and she came into the room to talk to [client C]. [Client C] was insistent that he have his porn. [AD] tried to discuss scheduling a meeting and [client C] continued to escalate. He stood up out of chair grabbed audible monitor and unplugged (sic) from the wall stating 'I don't want this s***, both [AD] and I tell (sic) him we are worried about him falling and would like him to sit down and we can talk. [Client C] then took his gait belt off and threw to (sic) floor and remained standing." Client C threw a small item off his dresser, pounded his fists and then said, "I'm out of here" and ambulated down hall out door of home and down the road. [AD] followed [client C] to ensure safety. Other staff were near but not close due to [client C's] agitation. [Client C] eventually calmed down at end of road and allowed us to bring him a wheelchair so he could sit down and return to the home. [Client C] returned to his room, I observed him continually-he			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>reports being tired and winded-I again discuss (sic) concerns about his safety and do not want him to fall." Client C then agreed to the use of the monitor, use the gait belt, wheelchair and other equipment for safety. The note indicated the home health PT assessment indicated client C "does have some weakness"and her goal was to offer strengthening exercises and would see him "most likely" 2 times per week. The note indicated the RN had discussed with client C's PCP nurse the need for the adaptive equipment for client C, the need for CPAP and "expressed with Sleep Study results I was very concerned of some relation of the falls with his severe hypoxic episodes/sleep apnea and wanted that CPAP urgently." The note indicated client C was going to be assessed by a nurse on a daily basis.</p> <p>Observations on 11/2/15 from 3:30 PM to 3:50 PM were completed at the group home. Client C sat on the driveway in a wheelchair with staff #15 upon arrival by the surveyor. Client C then left at 3:40 PM with the PD to purchase a hobby item after the PD lowered a lift on the van, fastened his wheelchair once on the lift and secured the wheelchair in the van. The group home nurse was present in the home completing staff training documents. Staff #3 and #4 were present</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>in the home with clients E, G and F.</p> <p>Staff #15 was interviewed on 11/2/15 at 3:35 PM and indicated she had been trained on client C's adaptive equipment use of the gait belt, wheelchair, 1:1 status, and on his ISP and BSP (Behavior Support Plan).</p> <p>Nurse #1 was interviewed on 11/2/15 at 3:40 PM and indicated she had trained 60 staff on the use of adaptive equipment and body mechanics and indicated client C had continued to increase strength and she did not anticipate client C would need the full time use of the wheelchair for much longer.</p> <p>Client C's note from the home health agency (undated) was reviewed on 10/30/15 at 2:05 PM and indicated client C "was initially assessed on 10/28/15. He was very cooperative during assessment. Objective findings included lower extremity weakness, difficulty and decreased safety with ambulation, as well as balance deficits. Plan for PT to continue to focus on these areas of deficit. Today's intervention included initiation of seated home exercise programs with written instructions given. Gait training also performed with rollator walker, minimum assistance, and wheelchair following. Plan to continue to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>focus on improving gait, transfers, and strength for increased safety and reduced fall risk." The assessment included pictures of exercises for client C to perform for strengthening.</p> <p>An electronic message sent to all staff working with client C on 10/30/15 at 4:12 PM indicated the following:</p> <p>"Staff, In the event that [client C] is to get upset and take off without the use of the adaptive equipment and refuses your one on one staff assistance please ensure the following:</p> <ol style="list-style-type: none"> 1. Follow [client C] immediately 2. Take all appropriate adaptive equipment with you. At a minimumn (sic) the gait belt and the wheelchair. 3. Staff remaining at the home should contact the PC on call immediately. 4. Attempt to redirect [client C] to allow you to assist him with the adaptive equipment. Remind [client C] that you are concerned about his safety and do not want him to fall. 5. If [client C] complies to your request, assist him in returning back to the home with the use of the wheelchair. <p>If you have any questions please contact [PC] immediately.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>Thanks! [AD]"</p> <p>A Clinician Report for client C's Behavior Support Plan (BSP) date range 10/30/15-11/2/15 indicated during a behavioral incident between 9:26 PM until 10:10 PM, client C required the use of prn medication after he threatened to hurt another roommate and to go AWOL (away without leave). Client C calmed after the prn medication was administered.</p> <p>The AD was interviewed on 11/2/15 at 4:13 PM and indicated client C had required the use of prn medication in the past to control his behavior and the behavior he exhibited on 10/30/15 and on 11/1/15 was not unusual. She indicated more staff training had been completed that day, and client C had not had any falls. Client C had seen his PCP on 11/2/15 and had provided a physician's order for the use of client C's use of adaptive equipment.</p> <p>Staff training records were reviewed on 10/30/15 at 1:00 PM and indicated all staff listed as employees assigned to the group home with the exception of staff #8 (who was suspended) had received training on 10/29/15 on client C's fall risk plan and the use of his adaptive</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/09/2015	
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012			
(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>equipment.</p> <p>Staff training records were reviewed on 11/2/15 at 4:30 PM and indicated staff had been trained on 11/2/15 at 1:30 PM on client C's behavior plan, the requirement to use a wheelchair at all times and the use of a gait belt to assist him in transfers.</p> <p>The IMMEDIATE JEOPARDY was removed based upon observations completed in the group home of implementation of the facility's plan and after review of client records, nurse notes, physical therapy notes and staff training records to demonstrate implementation of the plan. The Area Director was notified of the removal on 11/2/15 at 5:00 PM. Though the facility's corrective action removed the immediate jeopardy, the facility remained out of compliance at the Condition level because the facility needed to demonstrate ongoing implementation of the corrective actions to protect client C.</p> <p>The facility failed to ensure staff were trained to competency to protect client B from his wheelchair falling over during transport as a result of improper securing of his wheelchair, and failed to train staff competently on the health needs of 3 of 4 sampled clients (clients B, C and D). The</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>facility failed to ensure staff implemented identified supervision needs for client A and failed to develop and implement effective corrective action to address staff's unsafe driving habits after they had been identified in an investigation. The facility failed to thoroughly investigate an incident involving client A being left alone and staff's unsafe driving. The facility failed to thoroughly investigate an allegation of abuse and neglect involving clients C, E and F.</p> <p>Findings include:</p> <p>1. The facility failed to implement its policy and procedures to prevent abuse, neglect and mistreatment for 4 of 4 sampled clients (clients A, B, C and D) and for 1 additional client (client F). The facility failed to document falls and report them to the administrator and to BDDS (Bureau of Developmental Disabilities Services) and to investigate falls requiring the use of emergency medical personnel to assist client C after falling. The facility failed to develop and implement effective corrective action to protect client C from falls after a history of falls was identified. The facility failed to ensure staff were trained to competency to protect client B from his wheelchair falling over during transport as a result of improper securing of his</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>wheelchair. The facility failed to ensure staff implemented identified supervision needs for client A and failed to develop and implement effective corrective action to address staff's unsafe driving habits after they had been identified in an investigation. The facility failed to thoroughly investigate an incident involving client A being left alone and staff's unsafe driving. The facility failed to thoroughly investigate an allegation of abuse and neglect involving clients C, E and F. Please see W149.</p> <p>2. The facility failed for 2 of 4 sampled clients (clients B and C), to document falls and report them to the administrator and to BDDS (Bureau of Developmental Disabilities Services) in accordance to state law. Please see W153.</p> <p>3. The facility failed for clients A, B and C, to thoroughly investigate falls involving clients B and C. The facility failed to thoroughly investigate an incident involving client A being left alone and staff's unsafe driving. The facility failed to thoroughly investigate an allegation of abuse and neglect involving clients C, E and F. Please see W154.</p> <p>4. The facility failed to develop and implement effective corrective action to protect client C from falls after a history</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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 falls was identified. The facility failed to protect client B from his wheelchair falling over during transport as a result of improper securing of his wheelchair, and failed to provide supervision and protect client A from impaired/unsafe driving by the same staff who failed to secure the wheelchair properly. The facility failed to implement effective corrective action to address the staff's unsafe driving habits after they had been identified in an investigation. Please see W157.</p> <p>5. The facility failed to train staff competently on the behavioral needs of 1 additional client (client F). Please see W191.</p> <p>6. The failed to train staff competently on the health needs of 3 of 4 sampled clients (clients B, C and D). Please see W192.</p> <p>This federal tag relates to complaints #IN00175282 and #IN00185516.</p> <p>9-3-2(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview, the facility failed to implement its policy and procedures to prevent abuse, neglect and mistreatment for 4 of 4 sampled clients (clients A, B, C and D) and for 2 additional clients (clients E and	W 0149	W 149 Staff Treatment of Clients The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.	12/09/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>F). The facility failed to document falls and report them to the administrator and to BDDS (Bureau of Developmental Disabilities Services) and to investigate falls resulting in injury, hospital visits and requiring the use of emergency medical personnel to assist client C after falling. The facility failed to develop and implement effective corrective action to protect client C from falls after a history of falls was identified. The facility failed to ensure staff were trained to competency to protect client B from his wheelchair falling over during transport as a result of improper securing of his wheelchair, and failed to train staff competently on the health needs of 3 of 4 sampled clients (clients B, C and D). The facility failed to ensure staff implemented identified supervision needs for client A and failed to develop and implement effective corrective action to address staff's unsafe driving habits after they had been identified in an investigation. The facility failed to thoroughly investigate an incident involving client A being left alone and staff's unsafe driving. The facility failed to thoroughly investigate an allegation of abuse and neglect involving clients C, E and F.</p> <p>Findings include:</p> <p>1. Observations were completed at the</p>		<p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: <ul style="list-style-type: none"> ○ Abuse, neglect and exploitation-what constitutes abuse, report expectations and investigation expectations (competency test provided) ○ How to document falls ○ When to contact the Program Coordinator ○ How to properly secure a wheelchair in the bus using the wheelchair tie downs for Client B ○ Training regarding the risk plans and health needs for Client C. ○ Review the supervision needs for Client A ○ Vehicle use and safe driving training · The Program Coordinator and Program Director will be retrained on the appointment process expectations, following physician recommendations and communication expectations with the nurse. · The Program Coordinator will be trained on when to contact the Program Director. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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 10/26/15 from 5:55 PM until 7:06 PM. Client C sat on his bed and asked staff #7 to assist him in removing his hospital bracelets, with the exception of the bracelet labeled "fall risk," which he wanted to remain attached to his wrist.</p> <p>The Program Coordinator (PC) was interviewed on 10/26/15 at 6:00 PM and stated client C had returned from the hospital "a couple of hours ago." He indicated client C had fallen on 10/23/15 and may have had the flu.</p> <p>Staff #10 was interviewed on 10/26/15 at 5:55 PM and indicated client C had a history of falls and staff used a gait belt to assist him.</p> <p>Client E was interviewed on 10/26/15 at 6:30 PM and stated client C had been "pushed" by staff #8 causing his fall on 10/23/15.</p> <p>Client C was interviewed on 10/26/15 at 6:31 PM. He stated staff #8 had "pushed me as in rushed. I fell flat on my face." When asked how staff #8 rushed him, client C stated, "Hurry up, we're going to be late. We were outside and I was about to get on the bus."</p> <p>Staff #4 was interviewed on 10/26/15 at</p>		<ul style="list-style-type: none"> · The Program Coordinator and Program Director will be trained on reportable incidents and notifying the administrator. · The Program Coordinator and Program Director will be retrained on implementing corrective actions to address staff performance concerns and regarding recommendations made from investigations. · The Program Director will be retrained on investigation expectations and completing thorough investigations. · The new nurse will be at the site weekly to help oversee the medical needs of the residents and complete assessments as needed. · The IDT is currently meeting weekly to address Client C's health care needs. The IDT will continue to monitor his needs and may change the need to meet weekly as his health care needs improve and/or stabilize. · Client C has been participating in Physical Therapy services within the home. · Client C now has a walker, patient lift, gait belt, mat for his floor, audible monitor, motion alarm, bed rails and a wheelchair to assist in preventing falls. · Client C has had one on one supervision to assist in fall prevention. The IDT continues to monitor the need for this level of supervision to continue. The IDT will make recommendations for this supervision to change as his health care needs improve and/or stabilize. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>6:50 PM and stated client C "is hard to supervise. He has fallen recently. The meds he's on make him drowsy-when he falls it's hard to catch him." Staff #4 indicated client C had a fall risk plan to use a gait belt and a walker. Staff #4 indicated if client C falls, staff were to call the HM (house manager)/PC and indicated emergency medical services staff had to assist with client C to get up after falls twice on 10/23/15. Staff #4 indicated she not been present when client C had fallen and had been able to stop him from falling by asking him to stand up straight.</p> <p>Observations were completed again at the group home on 10/27/15 from 7:10 AM until 8:38 AM. Staff #8 assisted client C to get up from his bed using a gait belt. Client C used a rolling walker to go to the kitchen and sat on a wooden kitchen chair. Staff #8 and #9 assisted client C to get up from the chair using a gait belt and to use his walker. Staff #9 showed staff #8 how to position the gait belt for client C and how to position client C to his walker to aid him in rising from the chair. Client C requested a wooden chair to sit on in the living room and sat on the chair without arms with his head slumped toward his chest and his eyes closed. Client C's color was pale and of a yellow tint, and he aroused and indicated he was</p>		<ul style="list-style-type: none"> · Client C will participate in programming to help him understand the need to use his adaptive equipment and to complete his physical therapy exercises. · Client C now has a C-pap machine in place. · Client C is participating in 15 minute checks throughout the night to monitor the use of his C-pap machine. · Client C was seen by his psychiatrist on 10-29-15 to monitor his psych needs. He will see the psychiatrist again in January or sooner if needed. · Client C continues to see his counselor to help address his mental health needs. · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · Daily nursing oversight for Client C was completed through 11-24-15. · Currently the nurse is assessing Client C three times a week. The IDT will continue to monitor the need for this level of supervision to continue. The IDT will make recommendations for this supervision to change as his health care needs improve and/or stabilize. · Client C's risk plans will be reviewed by the nurse. Revisions will be implemented as necessary. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>tired. Staff #9 assisted client C using a gait belt and asked him to count to 3 and stand using his walker. Client C stood up and used his walker to walk to his room. Staff #9 instructed client C to keep his walker close to him while he walked for stability and to assist him in standing straighter and complimented him on his ability to stand.</p> <p>Staff #8 and #9 were interviewed on 10/27/15 at 7:25 AM. Staff #9 indicated she was a CNA (certified nursing assistant).</p> <p>Staff #8 indicated he had not been trained on specific client interventions for client C, and client C had been found on the floor of his bedroom at 3:00 AM on 10/23/15 when he was working with staff #7 on the overnight shift. He indicated client C normally got up at 4:00 AM for his shower to give him extra time. He indicated he and staff #7 had attempted to get client C up using the gait belt, but weren't able to get him up. Staff #8 indicated he had called 911 and on-call staff, and due to the emergency (with client C on the floor) the fire department had arrived to assist client C to get up. Staff #8 stated, client C "went on with his day and showered. My shift was over and I was off the clock. I was walking him out and I don't know if he missed his step</p>		<ul style="list-style-type: none"> · The nurse will be trained on how to follow up with physician recommendations to ensure they are implemented and/or addressed by the IDT. · Competency training with the nurse was completed with staff on 10-28 and 10-29-15 which included one person transfers, two person transfers, use of a gait belt, wheelchair safety, and one person assist. · Training was completed by the nurse on 10-29-15 included body mechanics/safe transfers, updated fall risk plan for Client C, adaptive equipment and change in health status reporting. · The nurse will monitor staff documentation at a minimum of weekly and communicate with the necessary team members as needed. · The nurse will conduct quarterly staff observations to ensure continued competency over adaptive equipment, body mechanics/safe transfers. · Client Specific training for new staff will include body mechanics/safe transfers and the use of a gait belt. · The Program Coordinator will check adaptive equipment weekly to ensure compliance. · Client C's ISP will be updated to reflect his current needs. · The IDT will monitor trends and patterns in client reportable incidents. The IDT will convene as necessary to discuss an increase in reportable incidents such as falls. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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 driveway) or missed his footing, and I tried to stop it (fall). He's a pretty good sized guy-my size and just the momentum...we called 911 and then the HM (house manager)/PC. I told the HM I could leave, staff were here with him. I don't know what happened as I left. I normally clock out at 8:00 AM, it was after that."</p> <p>Staff #7 was interviewed on 10/27/15 at 8:20 AM. Staff #7 stated client C was currently asleep in his room, client C was better 2-3 weeks ago and has been "like this for a week." Staff #7 indicated client C had been experiencing medication adjustments. Staff #7 indicated she had been present when client C fell on 10/23/15 on the overnight shift and at 9:00 AM. She saw client C fall as she went around the back of the van to assist with the lift. She stated staff #8 "was right in front of him. He was walking to his car to leave and was not assisting [client C]." Staff #7 indicated client C took about 30 minutes to leave the kitchen to get to the van on the morning of 10/23/15 prior to his fall and was not rushed. She indicated she had not received client specific training for client C to assist him using the gait belt or address his falls.</p> <p>Client C's discharge orders from the</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> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: <ul style="list-style-type: none"> ○ Abuse, neglect and exploitation-what constitutes abuse, report expectations and investigation expectations (competency test provided) ○ How to document falls ○ When to contact the Program Coordinator ○ How to properly secure a wheelchair in the bus using the wheelchair tie downs for Client B ○ Training regarding the risk plans and health needs for Client C. ○ Vehicle use and safe driving training · The Program Coordinator and Program Director will be retrained on the appointment process expectations, following physician recommendations and 	
--	--	--	---	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>hospital were reviewed on 10/26/15 at 6:28 PM. The discharge orders indicated client C's clonazepam was reduced to 5 mg (milligrams) from 10 mg. There was no other information in regards to client C's diagnosis or instructions to address client C's follow up care.</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services were reviewed on 10/27/15 at 10:15 AM and included the following for client C:</p> <p>A BDDS report dated 5/8/15 indicated on 5/8/15 at 6:25 AM, client C fell during his shower. Staff reported client C bruised his bottom (size and specific location not indicated). Client C later stated, "that he may have hit his head when falling. PC (Program Coordinator) contacted the nurse consultant and was advised to take [client C] to the ER (emergency room). Corrective action indicated the PC would follow recommendations of (sic) nurse consultant and ER physician. Staff will continue to monitor for any changes and report concerns immediately."</p> <p>A BDDS report dated 10/3/15 indicated client C "was having chest pains and thought he was having a heart attack so staff called the ambulance were (sic) he was taken to the hospital and treated.</p>		<p>communication expectations with the nurse.</p> <ul style="list-style-type: none"> · The Program Coordinator will be trained on when to contact the Program Director. · The Program Coordinator and Program Director will be trained on reportable incidents and notifying the administrator. · The Program Coordinator and Program Director will be retrained on implementing corrective actions to address staff performance concerns and regarding recommendations made from investigations. · The Program Director will be retrained on investigation expectations and completing thorough investigations. · The new nurse will be at the site weekly to help oversee the medical needs of the residents and complete assessments as needed. · The medical charts for the site have been reviewed by the nurse. · The IDT will continue to monitor the needs of all of the clients. The IDT will convene to address and monitor the health care needs of the residents until they improve and/or stabilize. · The need for adaptive equipment for the residents will be reviewed. In the event that additional adaptive equipment is needed the IDT will obtain it per physician recommendations. · The Program Director/QIDP will review all ISP's to ensure that they are updated and completed on a 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 11/09/2015
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012		
(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>Hospital stated he was having an (sic) just pains and gave him tylenol. Hospital staff stated if chest pain continues after 3 to 4 days then go see his doctor." Corrective action indicated "Staff will continue to follow mentor (sic) policy as stated."</p> <p>A BDDS report dated 10/7/15 indicated on 10/7/15 at 7:10 PM, client C was found by the staff on the bedroom floor, "staff tried to help [client C] up, other client (unspecified) called ambulance, ambulance came and helped [client C] up, there appears to be no injury, but staff will continue to check throughout the shift." Corrective action indicated "Follow Mentors (sic) policy and Procedure on Falls."</p> <p>A BDDS report written by the PD dated 10/23/15 was reviewed on 10/23/15 at 12:20 PM and indicated at 9:00 AM, client C "was walking to the bus lift where his legs gave out and he fell chest first into (sic) the driveway. i (sic) evaluated him, no blood, did not loose (sic) consciousness, complained of pain in both wrist (sic), both legs, and in his face and right eye, called ambulance. [Client C] was taken to the hospital and kept for an overnight observation. Corrective action indicated "Follow Mentors (sic) policy on falls."</p>		<p>yearly basis or more frequently as the needs arise.</p> <ul style="list-style-type: none"> · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · All resident risk plans will be reviewed by the nurse. Revisions will be implemented as necessary. · The nurse will be trained on how to follow up with physician recommendations to ensure they are implemented and/or addressed by the IDT. · Competency training with the nurse was completed with staff on 10-28 and 10-29-15 which included one person transfers, two person transfers, use of a gait belt, wheelchair safety, and one person assist. · Training was completed by the nurse on 10-29-15 included body mechanics/safe transfers, updated fall risk plan for Client C, adaptive equipment and change in health status reporting. · The nurse will monitor staff documentation at a minimum of weekly and communicate with the necessary team members as needed. · The nurse will conduct quarterly staff observations to ensure continued competency over adaptive equipment, body mechanics/safe transfers. · Client Specific training for 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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
	An investigation into the incident on 10/23/15 dated 10/24/15 was reviewed on 10/27/15 at 12:20 PM and indicated the same information as provided in the BDDS report in regards to the incident. Staff #7, client C and the PC were interviewed as part of the investigation. Staff #7 indicated in her interview she was in the process of taking the clients out to the bus so they could go to day services. The interview indicated staff #7 stated "Everything was fine until [client C] just fell all of a sudden, [client C] told her his legs just give (sic) out and they don't want to work right sometimes, he was complaining about his wrist and legs hurting and that she called the Ambulance, the PC just pulled up." The PC indicated he had just pulled up to the group home and found that client C had just fallen. The PC indicated he went with client C to the hospital and the nurse wanted to keep client C overnight to run tests. Client C was interviewed and stated, "he was walking to the bus and his legs just gave out on him, his legs stops (sic) working from time to time and he was in some pain and wanted to go to the hospital." There was no evidence any other clients present were interviewed as part of the investigation into client C's fall on the driveway at 9:00 AM on 10/23/15.		<p>new staff will include body mechanics/safe transfers and the use of a gait belt.</p> <ul style="list-style-type: none"> · The Program Coordinator will check adaptive equipment weekly to ensure compliance. · The IDT will monitor trends and patterns in client reportable incidents. The IDT will convene as necessary to discuss an increase in reportable incidents such as falls. <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 Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: <ul style="list-style-type: none"> o Abuse, neglect and exploitation-what constitutes abuse, report expectations and investigation expectations (competency test provided) o How to document falls o When to contact the Program Coordinator o How to properly secure a wheelchair in the bus using the wheelchair tie downs for Client B o Training regarding the risk plans 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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 Preliminary Report of Alleged Adult Endangerment was reviewed on 10/28/15 at 9:30 AM and indicated " On 10/26/15 APS (Adult Protective Services) received the following report: ...Please see the attached police report from [county] regarding [client C] (Victim). Victim (client C) is mentally handicapped. Victim resides in a group home believed to be under the supervision of REM-Indiana Mentor/Occazio ...According to the police report, [client C] is around 5' (feet) 10" (inches) and weighs over 300 lbs (pounds). Officer [name] states in her report that this is the second time in two weeks that she has been to the home due to Victim falling in the driveway. The first occurrence was on 10/15/15. Also Officer [name] was advised that the [township name] Fire Department was out on Victim around 4:00 (AM/PM not specified) on this date, 10/23/15 due to victim falling out of bed. There is concern over a lack of staff or supervision at the group home to assist Victim and also inadequate equipment to accommodate Victim " An attached police report indicated a Case Narrative " On 10/23/15, I assisted with [township] Fire Department on an injured (sic) in a fall at [group home address]. This is a group home. This is the second time in 2 weeks that I have been to the group home</p>		<p>and health needs for Client C.</p> <ul style="list-style-type: none"> o Vehicle use and safe driving training <ul style="list-style-type: none"> · The Program Coordinator and Program Director will be retrained on the appointment process expectations, following physician recommendations and communication expectations with the nurse. · The Program Coordinator will be trained on when to contact the Program Director. · The Program Coordinator and Program Director will be trained on reportable incidents and notifying the administrator. · The Program Coordinator and Program Director will be retrained on implementing corrective actions to address staff performance concerns and regarding recommendations made from investigations. · The Program Director will be retrained on investigation expectations and completing thorough investigations. · The new nurse will be at the site weekly to help oversee the medical needs of the residents and complete assessments as needed. · The medical charts for the site have been reviewed by the nurse. · The IDT will continue to monitor the needs of all of the clients. The IDT will convene to address and monitor the health care needs of the residents until they improve and/or stabilize. · The need for adaptive 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>in regards to the same client falling in the driveway. The prior incident was 10/15/15. I was advised the fire department was requested around 04:00 on 10/23/15 due to [client C] falling out of bed. I was advised the fire department assisted [client C] in standing.</p> <p>On 10/15/15, [client C] had fell (sic) in the driveway. [Client C] is approximately 5'10" and weighs over 300 pounds. The fire department assisted [client C] in standing and getting him back into a van. The fire department requested a wheelchair due to the distance the van was due to where [client C] fell. A wheelchair was brought out from the facility that would not be large enough for a large adult let alone a client that is obese as [client C]. On this occasion [client C] was unsteady on his feet and was unable to walk without assistance. The fireman had to place each of [client C 's] legs into the van. The (sic) they had to push on his bottom to move him over so that the door would close. [Client C] attempted to assist but trembled as he tried to move his own weight. There was a small bus that was picking up some of the clients. It is my understanding that [client C] would have to climb the stairs in order to get on the small bus. The bus is equipped with a ramp. One of the firemen advised that someone from the</p>		<p>equipment for the residents will be reviewed. In the event that additional adaptive equipment is needed the IDT will obtain it per physician recommendations.</p> <ul style="list-style-type: none"> · The Program Director/QIDP will review all ISP's to ensure that they are updated and completed on a yearly basis or more frequently as the needs arise. · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · All resident risk plans will be reviewed by the nurse. Revisions will be implemented as necessary. · The nurse will be trained on how to follow up with physician recommendations to ensure they are implemented and/or addressed by the IDT. · Competency training with the nurse was completed with staff on 10-28 and 10-29-15 which included one person transfers, two person transfers, use of a gait belt, wheelchair safety, and one person assist. · Training was completed by the nurse on 10-29-15 included body mechanics/safe transfers, updated fall risk plan for Client C, adaptive equipment and change in health status reporting. · The nurse will monitor staff documentation at a minimum of 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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 advised that there has not had (sic) a manager for some time. They also advised that the clients are shipped from this facility to another due to being understaffed during the daytime. The staff was little to no help in getting [client C] on the van.</p> <p>On 10/23/15, [client C] was lying face down on the driveway, which is a slight decline. His face was toward the downward slope and facing opposite of the house. [Client C] had a blanket draped over him, but he was shaking. I spoke to [client C] and he complained of pain to his head. There was no blood or obvious injuries that I could see. [Client C] stated the staff tell him it is his fault that he falls because he gets in too big of a hurry. A walker was close to [client C]. One of the fire personnel advised the walker appeared to be too small for the size of [client C].</p> <p>I overheard one of the staff say his medication was changed and there should be improvements.</p> <p>The concern in if the equipment for [client C] is adequate for his size, as well as if there is adequate staff to deal with [client C ' s] needs. [Client C] is a mentally disabled individual and may not be able to adequately express his needs or</p>		<p>weekly and communicate with the necessary team members as needed.</p> <ul style="list-style-type: none"> · The nurse will conduct quarterly staff observations to ensure continued competency over adaptive equipment, body mechanics/safe transfers. · Client Specific training for new staff will include body mechanics/safe transfers and the use of a gait belt. · The Program Coordinator will check adaptive equipment weekly to ensure compliance. · The IDT will monitor trends and patterns in client reportable incidents. The IDT will convene as necessary to discuss an increase in reportable incidents such as falls. <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 to ensure the clients plans and needs are being met during their bi-weekly observations. · The Program Coordinator will monitor to ensure the clients plans and needs are being met during their weekly observations. · Mentor's nurse will be in the home on a weekly basis or more frequently as needed to monitor for concerns and assess residents. · New staff hired to work at the site will receive client specific training for each individual prior to working a shift. This training includes items such as: client's diets, risk plans, ISP's, programming, and 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>provide for himself to attain what he needs. " There was a note at the bottom of the report "Forward to Adult Protective Services. "</p> <p>There was no evidence in reports provided by the facility the incident of client C falling on October 15, 2015 had been reported to the administrator, BDDS, investigated or of corrective action taken to address client C' s fall.</p> <p>The Area Director (AD) was interviewed on 10/27/15 at 12:15 PM and indicated client C's falls which required the use of emergency personnel should have been reported to her and to BDDS.</p> <p>Client C's record was reviewed on 10/27/15 at 12:55 PM. A visit to client C's primary care physician dated 9/14/15 indicated client C weighed 333.9 pounds in 4/15. There were no other records found to indicate client C's weight. There was no evidence of an updated Individual Support Plan since his last ISP dated 3/4/15.</p> <p>A Risk Plan updated on 10/27/15 and previously updated on 10/14/11 indicated client C's risks included, but were not limited to medication side effects, Depression, Intermittent Explosive Disorder, Personality Disorder, Obesity,</p>		<p>medication review.</p> <ul style="list-style-type: none"> · The nurse will be available to do observations within the home for medical related issues as the client's needs indicate. · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · Monthly supervisory visit check sheets to be completed by the QIDP. These will be forwarded to the Area Director for review. · Quarterly Health and Safety assessments will be completed by the Program Coordinator and/or the Program Director and forwarded to the Quality Improvement department. These assessments include a review of the environmental needs for the home, review of risk plans, ISP, BSP and client specific training for the residents. The assessment also includes an interview of staff to ensure they know how to properly document medical needs, how to report incidents, diets and understanding of BSP's. · The Quality Improvement Department and the Area Director will monitor incidents as they are reported to ensure that they are reported timely and that all required incidents are reported to BDDS. · New staff hired to work at the site will receive training on 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>Phlebitis (blood clots), warfarin (blood thinner/anti-coagulant) therapy, and history of falls. Client C's risk for warfarin therapy indicated "Warfarin can cause very serious (possibly fatal) bleeding." Client C's falls risk indicated he "has a history of falls and at risk for falls. [Client C] is to be using w/c (wheelchair) and gait belt PRN (as needed) for increased unsteady gait. Staff are to ensure environment free from fall hazards (rugs, cords, etc), if fall occurs assessment to be completed and PC/PD to be phoned regarding fall. If (sic) sustains injury that appears severe/life threatening in nature, they are to initiate EMS (emergency medical services) prior to notification of PC/PD. Obtain vitals and document accordingly." The plan failed to indicate how many staff were to assist client C in using the gait belt, transferring or specific information as to when client C was to use the wheelchair and gait belt and how staff were to assist him with the adaptive equipment. The plan failed to indicate the use of client C's rolling walker.</p> <p>IDT (interdisciplinary) meeting notes on 10/16/15 in client C's record entered by the Behavior Analyst (BA) indicated client C "has been observed falling asleep, having difficulty walking, standing, getting out of bed." The note</p>		<p>reportable incidents, reporting expectations and who to contact.</p> <p>All abuse and neglect investigations will be reviewed by the Quality Improvement Specialist or her designee to ensure the investigations are thorough.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>indicated client C's psychiatrist nurse practitioner (NP) had "increased Seroquel (anti-psychotic) from 400 mg (milligrams) daily to 400 mg BID (twice daily), changed Depakote (seizures/mood stability) from 2,000 mg at bedtime to 1,000 mg BID, changed Clonazepam (anxiety) from 1 mg BID to 1 mg TID (three times daily), added Zyprexa Zydis 5 mg PRN (as needed) for agitation on September 16, 2015. After med (medication) change, staff nurse, [name] stated [client C] had increased his falls over the weekend and contacted [client C's] [primary care physician (PCP)] to request a med decrease of Seroquel. [PCP], decreased Seroquel back to 400 mg daily-other psych med changes made by [NP] were continued. Even after dosage change of Seroquel, [client C] displays frequent difficulty ambulating requiring the fire department to be contacted three times during the month of October to assist staff in helping [client C] get up/ambulate. [Client C] has also been taken to the ER twice since his admission due to reports he was having a heart attack on one occasion and reports he was having difficulty walking on the second occasion-no medical confirmation was made at either ER visit. [Client C] had some med changes that occurred at the nursing home prior to his admission to the group home on September 11,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>2015. Said changes that included Provigil discontinued and Keppra added. [Client C] has completed labs to check Depakote and ammonia levels. [Client C] has also recently completed a sleep study. We do not currently have lab results or sleep study results...Recommendations: 1) PC/PD will schedule an appt (appointment) with [PCP] to address: recommendations regarding Provigil (medication to increase alertness); recommendations regarding need for Keppra (seizures); discuss results and get copies from sleep study; request order for wheelchair PRN; discuss order for use of gait belt at all times except when [client C] is seated in his wheelchair and in bed; request order for OT (occupational therapy)/PT (physical therapy) evaluation; request an order for new ted hose (support stockings). 2) PC/PD will begin a 24 hr (hour) sleep chart so [client C's] sleeping can be tracked at the day service and the group home. 3) PC/PD will contact the lab facility to request copies of [client C's] recent labs-results will be scanned to therap (electronic/digital recording system). 4) [Client C's] level of agitation and threats of physical harm to others has decreased since he has had increased medical issues-it is recommended by the staff nurse [name], that staff refrain from using the Zyprexa Zydis PRN medication</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>as [client C] is not currently a physical harm to others. If staff question [client C's] agitation and feel he is a threat to himself or others, the PC/PD should be contacted...."</p> <p>Client C's MAR (medication administration record) dated 10/2015 failed to indicate a sleep chart for client C, the use of a wheelchair or of a rolling walker. The MAR indicated client C's gait belt may be used prn (as needed). The MAR indicated the use of clonazepam .5 mg twice daily and listed the side effect of drowsiness, depakote ER (extended release) 2,000 mg, with a side effect of drowsiness, Keppra (seizures) 500 mg twice daily with a side effect of drowsiness, weakness and dizziness, perphenazine (psychosis) 6 mg with side effects of dizziness, drowsiness and anxiety, Seroquel (anti-psychosis) 400 mg daily with a side effect of drowsiness, and warfarin 6 mg daily and Zyprexa Zydis 5 mg (anti-psychotic) every 8 hours as needed.</p> <p>A General Event Report (GER) in client C's record dated 5/18/15 indicated in the section Event Information "Describe what happened before the event: don't know, client says it happened this morning when another peer was helping him up from the floor...Comments: client</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>says he couldn't get up off the floor, asked him if he fell out of bed, he said trying to get out of bed and slid to floor. Told me staff was aware...." The sections for Corrective Action Taken, Plan of Future Corrective Actions and Follow-Up actions, were blank. The report indicated the residential manager (PC) was notified by staff #2 on 5/18/15 at 8:31 PM. The PD (Program Director)/QIDP (Qualified Intellectual Disabilities Professional) reviewed the report on 5/19/15 at 9:50 AM. There was no evidence the incident was reported to the Area Director or the group home nurse was notified of the incident. There was no evidence in the report of an assessment to determine if client C was injured during the incident. There was no evidence the incident was investigated.</p> <p>A GER dated 6/2/15 indicated client C "was sick last night, staff monitored all night. [Client C] got up this morning and was not feeling well still, had high temp (temperature) (not specified) and low O2 (oxygen level in the blood stream). He was taken to doctor and sent to the emergency room...Comments: [client C] was admitted into the emergency room because of his condition, as of 3 pm he was being admitted into the ICU (intensive care unit)." There was no corrective action or follow up listed in</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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 report. A BDDS report attached to the GER indicated on 6/2/15 at 11:30 AM, client C was taken to the hospital after being sick all night with a high temperature and low O2 saturations. Corrective action indicated "I told the staff to do the same thing if he complains about it a lot, then take him to the hospital. So we would use the same plan as before."</p> <p>T-Log nursing notes were reviewed on 10/28/15 at 9:50 AM and indicated on 10/6/15, "Called and spoke with [PD] on Sunday regarding [client C], stated hospital states did not have a heart attack, give tylenol as needed. Checked up on [client C] on Monday (date not specified), he appeared tired from increase in psych (psychotropic) meds (medications) but was alert and able to carry on conversatin (sic), c/o (complains of) knees hurting, no other distress noted." The note failed to indicate any follow up action to address client C's chest pain, appearance of being tired or of his knee pain.</p> <p>A note from the nurse dated 10/7/15 indicated PD "notified order received last night to decrease seroquel to 400 mg (milligrams) daily due to lethargy. Called [primary care physician's] office and requested new script for calcium citrate</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>and fax order for seroquel decrease. Client more alert today...."</p> <p>A nursing note dated 10/9/15 indicated "Client refused body assessment, states, 'I'm OK,' called [primary care physician's] office 2nd time and asked about new script for calcium citrate, awaiting orders."</p> <p>A nursing note dated 10/12/15 indicated client C "continues to deny any injuries from fall, denies any further pain in his chest, c/o right knee pain, no swelling noted, left thumb healing, nail healing and coming off, no s/sx (symptoms) of infection, area pink, no swelling noted."</p> <p>A nursing note dated 10/26/15 at 12:38 PM indicated a social worker at the hospital wanted to talk to her about PT (physical therapy) for client C. The note indicated he would be referred to a home health agency to evaluate and treat client C's needs. The social worker "further advised he will be discharged today-I requested records from his stay be sent with staff upon discharge so we may have in his chart and she advised she would ensure a packet would be made and sent. She could not advise as to any changes in medication. PD/AD/PC advised of above and requested to schedule follow up with [PCP] immediately."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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 note dated 10/27/15 at 9:15 AM indicated "Upon review of discharge orders it is noted that perphenazine and warafin (sic) orders are changed as well. I phoned [Hospital] and spoke with [name] who was working on floor [client C] was on..." The discussion with the nurse at the hospital indicated client C's warfarin (blood thinner) and perphenazine were to be continued as they were upon admission at 6 mg daily warfarin and 6 mg TID of perphenazine. The note indicated client C was to be scheduled for PT evaluation within 48 hours and the PC was aware. The note indicated client C was to see his PCP on 11/2/15.</p> <p>A nursing note dated 10/27/15 indicated client C was assessed and when awakened, indicated he was OK. Client C's vital signs were normal and the nurse noted client C was "somewhat lethargic during assessment but could have just been tired."</p> <p>Additional T-Log nursing notes were reviewed on 10/28/15 at 3:50 PM. A nursing note dated 10/28/15 at 2:51 PM indicated client C was sleeping, but awakened easily. "He was independent in undressing and transferring to his w/c wheelchair...Staff commented that [client C] was more alert and mobile than he has</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>been recently...."</p> <p>A note dated 10/28/15 at 3:08 PM indicated client C was being referred for a CPAP (continuous pressure airway machine) and client C's PCP had sent orders for PT evaluation and treatment and had requested an order for a wheelchair and gait belt for "safety purposes."</p> <p>A nursing note dated 10/28/15 at 3:12 PM indicated the nurse had checked on another client and while at the group home, checked on client C, "I was surprised to see him up and alert and oriented a totally different person that I had assessed 4 hours earlier...."</p> <p>A Polysomnography Report (evaluation of sleep quality) was reviewed on 10/27/15 at 11:45 AM and indicated client C had been diagnosed with "severe obstructive sleep apnea with significant oxygen desaturations," with a total of 305 respiratory events and a calculated apnea (stopping and starting sleep)/hypoxia (lack of oxygen) was 50 events per hour. Client C had an oxygen saturation below 89% for a total of 150 minutes. The report indicated a recommendation to use a CPAP machine to aid in preventing airway obstruction during sleep.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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 Mayo Clinic website mayoclinic.org reviewed on 10/29/15 at 2:30 PM indicated sleep apnea is a "potentially serious sleep disorder in which breathing repeatedly stops and starts." A side effect listed on the website indicated tiredness even after a full night's sleep.</p> <p>Indiana Mentor Meeting Notes dated 10/19/15 indicated "Discussed falls with [client C] and how to get him up in the morning." There was no additional evidence of specific information in regards to how staff were to assist client C to get up in the morning. Staff present at the meeting included the PC, staff #6, staff #3, staff #4 and day services coordinator #1. There was no evidence staff #2, #5, #7, #8 or #9 as listed on the staff list provided at the entrance of the survey were present or had been provided information from the meeting.</p> <p>The group home nurse was interviewed on 10/27/15 at 11:30 AM and indicated she had just transferred to the group home on 10/26/15 and the Area Director (AD) should be able to provide evidence of staff training for client C's updated risk plan.</p> <p>The AD and Regional Director were interviewed on 10/28/15 at 3:40 PM and indicated client C's risk plan should be</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>specific as to how staff were to use the gait belt, when to use the wheelchair and walker and how to assist client C if he were to fall.</p> <p>An electronic/digital message sent to all staff working in the group home dated 10/27/15 at 2:21 PM was reviewed on 10/28/15 at 3:53 PM and indicated client C "is to remain in his wheelchair at all times per hospital orders until further notice." There was no evidence of a physician's order for the use of client C's wheelchair or of staff training to use the wheelchair, transferring client C, assisting him in using the gait belt or what to do if client C fell.</p> <p>The AD was interviewed on 10/28/15 at 3:53 PM and indicated there was no evidence staff had not been trained on client C's plan updated on 10/27/15.</p> <p>The PD was interviewed on 10/28/15 at 4:00 PM and stated, "I didn't elaborate with the notes," and indicated he had instructed staff to use the wheelchair or call the on-call supervisor if client C fell. He indicated he had demonstrated how client C was to be lifted under his arms and how to use the wheelchair. The PD stated, "Sometimes his legs don't work," and stated "We would use a sling (gait belt)" and had demonstrated its use at the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>meeting. The PD indicated staff #7 and #8 had not attended the meeting and there was no additional training since client C's fall on 10/23/15.</p> <p>The AD was interviewed on 11/2/15 at 5:20 PM and indicated the nurse, PD and the PC should have noticed a pattern of client C's falls and addressed them.</p> <p>2. A BDDS report dated 5/23/15 and reported 5/28/15 indicated "staff stated that he was driving the Vehicle to drop off another client at workshop. He turned a corner and rear passenger side strap failed and released tension causing the chair to fall over. Client B was unharmed but needed to be picked up by three individuals because the wheelchair was heavy." Corrective action indicated "Retrain Staff on reporting incident, bus safety, as well as contact PC or PD as soon as accident happens."</p> <p>An investigation dated 6/1/15 completed by the PD was reviewed on 10/27/15 at 11:00 AM and indicated the following interviews with clients A, E, F and B and by staff #15:</p> <p>Client E indicated in an interview on 6/2/15 he saw client B fall over on his side and "he had to yell at [staff #15] twice to stop the bus because [client B]</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>was over on his side...stated that he said something to him (unspecified) about the straps being put on correctly (sic) he also stated that [staff #15], [client F] and himself had to lift [client B] off the ground. Stated that the music was up a little loud and that's why he had to yell twice at [staff #15] to get his attention to stop the bus."</p> <p>Client B indicated in an interview on 6/2/15 "stated that he felt like [staff #15] was driving fast on that day. Stated that he felt his straps was (sic) not put on correctly and said that [client E] said something to [staff #15] about the straps not being on right. [Client B] stated that he (unspecified) had the radio loud and couldn't hear him. [Client B] stated that he was telling [staff #15] he was falling over and presumed to turn up the radio. Stated that once he fell over [client E] yelled at [staff #15] to stop the bus. [Client B] stated that [client E] tried to pick him up but was too heavy and by that time [client F] and [staff #15] was (sic) helping lift him."</p> <p>Client A indicated in an interview on 6/2/15 "they had to call [staff #15] a few times to get his attention," and indicated staff #15, and clients E and F assisted client B up off the ground and secured the straps.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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 F indicated in an interview on 6/2/15 client E had to call staff #15 twice to get his attention after client B fell over before staff #15 stopped to get client B up and secure the tie downs to his wheelchair before driving client A to work.</p> <p>Staff #15 indicated in an interview on 6/3/15 "that [client F] and a few others yelled at him and he said once he looked back and seen (sic) [client B] was on the ground he had to pull over. Stated the rear right hand side belt failed and released...." When staff #15 was asked why he didn't report it, "Stated he di dn't report it because it just slipped his mind because he had a lot going on that weekend with his fiance being in the hospital...."</p> <p>The conclusion of the investigation indicated "Evidence supports staff did not follow protocol(s). Recommendations/Corrective Measures to Prevent the Likelihood of Future Occurrences: Staff will be retrained on and sign off on call procedures and attendance policy. Staff will be retrained on tie-downs. Staff will monitor an injury's (sic) for [client B] and report concerns immediately."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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 (AD) was interviewed on 10/27/15 at 11:35 AM and indicated staff #15 should have received corrective action of re-training on tie downs as indicated in the investigation. She indicated the investigation should have addressed the client's statements about staff #15 driving fast and having the music on so loud he could not hear them yelling when client B fell over in his wheelchair.</p> <p>Staff #15's Behind the Wheel Company Vehicle Driving Training Checklist dated 8/4/14 was reviewed on 11/4/15 at 1:45 PM and indicated staff #15 had been trained on safe driving, including "maintains a safe following distance and speed limits," and "did lift w/(with) empty w/c (wheelchair). Still needs tie down training."</p> <p>The AD indicated on 11/5/15 at 11:59 AM, there was no evidence staff #15 had been retrained on vehicle tie-downs or van safety at the group home.</p> <p>3. A BDDS report dated 6/6/15 at 10:23 PM indicated "[Client A] and [Client I] were on an outing with [staff #15] and upon arriving back home the other staff working [staff #6] seen (sic) that something was wrong with [staff #15]. It was reported to [staff #6] that [staff #15]</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>took [client A] and [client I] on a location not approved by the PD or PC. It was report (sic) to [staff #6] that [client A] and [client I] may have been left in the van up to 30 minutes unintended (sic). It was reported that [staff #15] was suspected to be under the influence of something and was found in the living room asleep on the couch. Upon reciving (sic) these concerns [staff #6] contacted the on call PC and the on call PC informed the PD and the PD went to the home and found [staff #15] sleep (sic). PD suspended [staff #15] immediately and sent him home. PD checked to make sure everyone in the house was safe. PD also was in contact with other home manager for [client I] to inform them of the situation and ensure [client I's] safety. There was (sic) no injuries observed and reported." Corrective action indicated "Staff has been suspended upon completion of (sic) investigation."</p> <p>A Summary of Internal Investigation Report dated 6/10/15 was reviewed on 10/27/15 at 10:40 AM and indicated the following:</p> <p>An undated interview with PC #3 indicated she had received a call from staff #6, reporting that staff #15 was "passed out" in the office. Staff #6 indicated to PC #3 that staff #15 had left</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>"approximately 6 pm with the client [client A], and returned to the home at 9:40 PM. Said [staff #6] told her [staff #15] appeared to be having trouble walking into the home when he returned. Said [client A] had reported to [staff #6] that [staff #15] had taken him and [client I] to his home, got out of the car without saying anything to them and left them in the car for a period of time and when they were coming home [staff #15] was driving 'reckless'...."</p> <p>An undated interview with the PD indicated when he arrived at the group home at 11 PM, "[staff #6] informed him that [staff #15] was still asleep and she was afraid he might come up swinging when he was awakened. Said he observed [staff #15] lying on the couch on his side with a pillow under his head, his shoes off, and a blanket covering him to his neck. Said he tapped [staff #15] several times and asked him to wake up. Said when [staff #15] did not wake up he shook [staff #15's] leg and spoke louder. Said [staff #15] then open (sic) one eye and looked at him. Said he directed [staff #15] to get up and leave. Said [staff #15] got up from the couch without saying anything and stood looking at him for several minutes before he again informed [staff #15] he needed to get his shoes on and leave. Said [staff #15] then got his</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>shoes and left slamming the door without saying a word....Said when he interviewed [client A], [client A] looked concerned. [Client A] told him [staff #15's] driving scared him. [Client A] said [staff #15] hit a median and almost hit another car demonstrating with his hands. [Client A] said [staff #15] was acting different on their way home...Said [client A] and [client I] require supervision during their dates to reduce opportunities for inappropriate sexual behavior between them. Said [client A] told him he and [client I] kissed while they were waiting for [staff #15] to come out of the house...Said he did receive a text on 6/7/15 from [staff #15]."</p> <p>An undated interview with client A indicated he and client I were taken to a restaurant for about 30 minutes and then went to the house where they have never been before. "Said [staff #15] left them in the car for 30 minutes while he was in the house. Said on the way home he was scared because [staff #15] hit a median and almost hit another car...."</p> <p>An undated interview with client E indicated staff #15 "sleeps whenever he works by himself."</p> <p>An undated interview with staff #15 indicated he "fell asleep on 6/6/15"</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>because the medication he has been prescribed makes him drowsy." Staff #15 denied taking client A and client I anywhere other than driving around so that they could spend time together."</p> <p>There was no evidence in the investigation that client I had been interviewed.</p> <p>The conclusion of the investigation indicated staff #15 admitted he was sleeping on 6/6/15 and was under the influence of medication when transporting clients. Recommendations indicated "HR (human resources) and Operations (administrative staff) to review findings of investigation to determine appropriate corrective action."</p> <p>Client A's record was reviewed on 10/27/15 at 1:05 PM. An ISP (Individual Support Plan) last updated 5/8/14 indicated client A "has to have staff with him on all community outings." The Individual Services Safeguard last updated 2/18/11 indicated for supervision in the community client A required "within visual range (consumer is within eyesight of staff at all times)."</p> <p>The Area Director (AD) was interviewed on 10/27/15 at 11:35 AM and indicated staff #15 had been terminated after the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>incident on 6/6/15 involving client A. She indicated staff #15's erratic driving under the influence of medication and failure to supervise him had placed client A at risk. She indicated the facility's policy and procedures did not permit staff #15 to be screened for substances he may have been under the influence of at the time of the incident involving client A. She indicated there was no evidence in the investigation client I had been interviewed. The AD indicated corrective action to ensure clients were not at risk included ongoing monitoring by the group home PC (Program Coordinator) on a daily basis and by the PD (Program Director) on a weekly basis. She indicated she would look for evidence of monitoring by the PC and PD.</p> <p>The AD was interviewed on 11/2/15 at 5:10 PM and when asked about evidence of PC monitoring visits, indicated she would look for documentation, and stated, there were "not too many." There was no evidence of monitoring/observations by the PC provided prior to 10/28/15.</p> <p>Documentation of the PD's monitoring of the group home was reviewed on 10/27/15 at 10:35 AM and indicated he had visited the home on 6/11/15 from 4:00 PM until 5:30 PM, on 7/16/15 from</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/09/2015
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012		
(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>12:00 PM-1:00 PM, on 9/12/15 from 10:00 AM until 11:30 AM, on 9/29/15 at 9:30 AM and again on 10/15 from 1:00 PM until 3:30 PM. There was no evidence of visits on a weekly basis.</p> <p>Client A was interviewed on 10/29/15 at 7:55 PM. When asked about the incident in which staff #15 had left him and client I alone on the van, he stated it was his birthday that day and he and client I had gone out to eat. Staff #15 then drove them to an unknown location/home and staff #15 left him and client I alone "for awhile." Client A indicated when staff #15 drove him and client I home, he was weaving (as demonstrated by moving his hands) on the road. Client A indicated he was scared when staff #15 drove him home that evening.</p> <p>4. Observations were completed at the group home on 10/26/15 from 5:55 PM until 7:06 PM. Client C sat on his bed and asked staff #7 to assist him in removing his hospital bracelets, with the exception of the bracelet labeled "fall risk," which he wanted to remain attached to his wrist.</p> <p>The Program Coordinator (PC) was interviewed on 10/26/15 at 6:00 PM and stated client C had returned from the hospital "a couple of hours ago." He</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>indicated client C had fallen on 10/23/15 and may have had the flu.</p> <p>Client E was interviewed on 10/26/15 at 6:30 PM and stated staff #8 "Is demanding. I know this is our house, but I feel like it's not our house." Client E stated client C had been "pushed" by staff #8 causing his fall on 10/23/15.</p> <p>Client C was interviewed on 10/26/15 at 6:31 PM. He stated staff #8 had "pushed me as in rushed. I fell flat on my face." When asked how staff #8 rushed him, client C stated, "Hurry up, we're going to be late. We were outside and I was about to get on the bus."</p> <p>Client F was interviewed on 10/26/15 at 6:20 PM and stated staff #8 "bosses me around," and staff #8 would tell client F to "Get this done." When asked if he had informed anyone, he indicated he had told the PC (Program Coordinator) who was standing in the area.</p> <p>The PC was interviewed on 10/26/15 at 6:20 PM and indicated he had been made aware of clients E and F's concerns of staff #8's approach earlier that week (date not specified) and was going to address it with staff #8.</p> <p>Staff #4 was interviewed on 10/27/15 at</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>7:40 AM and stated she had heard clients complain about staff #8 " bossing " clients. She indicated staff #8 was sometimes directive in requests and she had attempted to demonstrate how to ask clients to complete tasks by asking them " Could you please? "</p> <p>The Area Director (AD) was interviewed on 10/27/15 at 12:20 PM and indicated staff #8 was currently suspended due to an allegation made by client F that morning of misconduct.</p> <p>A Summary of Internal Investigation Report dated 11/4/15 for an incident dated 10/29/15 indicated on 10/29/15, the AD suspended staff #8 for "being bossy." The following interviews were completed as part of the investigation:</p> <p>Client C was interviewed (undated) and indicated he was walking to the bus and "his legs just gave out on him ([client C] fell going to the van on 10/29/15...Stated he felt rushed because [staff #8] was telling everyone to hurry up...Stated he doesn't like [staff #8] because he wakes me up on (sic) the morning and doesn't wake everyone else up on the morning. Stated he feels like this is [staff #8] being bossy. States an example of [staff #8] being bossy is 'Pushy, meaning talking to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>me real fast, telling me to hurry up. Stated [staff #8] has only been bossy on the day he [client C] fell when he had the walker...."</p> <p>Client B's undated interview indicated staff #8 was not bossy to him, but "sometimes [staff #8] is bossy to [client H]."</p> <p>Client E's undated interview indicated "things are not going good because [staff #8] is irritating...Stated he doesn't like the way [staff #8] speaks to them and he feels like he's in the military. Stated [staff #8] is bossy to everybody. Stated [staff #8] has yelled at him and raised his voice but could not give specifics...."</p> <p>Client F's undated interview indicated " things are not going good because of [staff #8]. Stated [staff #8] is bossy. Stated [staff #8] will go into his bedroom and hook his phone up to the surround sound in my bedroom. Stated he wants to get rid of [staff #8]. " Staff #8 " demands " client F to wash the table as part of his assigned chores and staff #8 has yelled at him and raised his voice. When asked if [staff #8] has been physically abusive towards him states, 'yes, he punches his hand. ' "</p> <p>Staff #4's undated interview indicated</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>"she had never seen [staff #8] be bossy towards clients."</p> <p>The PD's undated interview indicated he had interviewed clients G, E and H. The interview indicated the clients did not think staff #8 raised his voice, and staff #8 "just tells them what to do," and client H did not like to get up at 5:00 AM when staff #8 woke him up with the other clients. The PD "Stated the clients he spoke to said if a female were to ask in the same manner and tone as [staff #8] it would not be a problem. "</p> <p>Staff #8's undated interview indicated staff #8 "Just wakes them up and lets them know from time to time they are running behind, but he has never been bossy or mean to them."</p> <p>The conclusion indicated "evidence does not support the allegation of verbal abuse from [client F] involving [staff #8], and [staff #8] will be retrained on how to speak to clients."</p> <p>The AD (Area Director) was interviewed on 11/9/15 at 4:35 PM and indicated the investigation did not address client F's statement staff #8 hit his hand or the discrepancies between the statements of clients C, E and F and the PD.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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 facility's policy Quality and Risk Management dated 4/2011 was reviewed on 10/27/15 at 10:30 AM and 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... B.1. Alleged, suspected, or actual abuse, neglect, or exploitation of an individual. An incident in this category shall also be reported...as applicable. The provider shall suspend staff involved in an incident from duty pending investigation by the provider. This may include: ...e. Failure to provide appropriate supervision, care or training; ... 4...h. Injury to an individual when the origin or cause of the injury is unknown and could be indicative of abuse, neglect or exploitation; i. Injury to an individual when the origin or cause of the injury is unknown and the injury required medical evaluation or treatment. j. A significant injury to an individual, including; (1) A fracture; ... (4) Bruises larger then three inches in any direction or pattern of bruises or contusions regardless of size; (5) Any occurrence of skin breakdown related to decubitus ulcer regardless of severity; (6) Contusions or lacerations</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>which require more than basic first aid; (7) Any injury requiring more than first aid; (8) Any puncture wound penetrating the skin, including human or animal bites; or (9) Any pica ingestion requiring more than first aid. l. A fall resulting in injury, regardless of severity of injury...p. Inadequate staff support for an individual, including inadequate supervision, with the potential for: (1) Significant harm or injury to an individual; or (2) Death of an individual; q. Inadequate medical support for an individual, including failure to obtain: 1. Necessary medical services; 2. Routine dental or physician services; ... 4. An incident shall be reported by a provider or an employee or agent who: (a) Is providing services to the individual at the time of the incident. (b). Becomes aware of or receives information about an alleged incident. 5. An initial report regarding an incident shall be submitted within twenty-four hours of: (a) the occurrence of the incident; or (b). the reporter becoming aware of or receiving information about an incident. The Program Director, who serves as the QMRP (Qualified Mental Retardation Professional), shall submit a follow-up report concerning the incident on the BDDS's follow-up incident report form at the following times: (a). Within seven days of the date of the initial report; (b). Every seven days thereafter until the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>incident is resolved; (c). All information required to be submitted to the BDDS shall also be submitted to the provider of case management services to the individual... C. Indiana Mentor is committed to completing a thorough investigation for any event out of the ordinary which jeopardizes the health and safety of any individual served or other employee. 1. Investigation findings will be submitted to the Area Director for review and development of further recommendations as needed within 5 days of the incident."</p> <p>This federal tag relates to complaints #IN00175282 and #IN00185516.</p> <p>9-3-2(a)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/29/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	<input checked="" type="checkbox"/> X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	<input checked="" type="checkbox"/> X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	<input checked="" type="checkbox"/> X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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
W 0153 Bldg. 00	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on observation, record review and interview for 2 of 4 sampled clients (clients B and C), the facility failed to document falls and report them to the administrator and to BDDS (Bureau of Developmental Disabilities Services) in accordance to state law.</p> <p>Findings include:</p> <p>1. The Program Coordinator (PC) was interviewed on 10/26/15 at 6:00 PM and stated client C had returned from the hospital "a couple of hours ago." He indicated client C had fallen on 10/23/15 and may have had the flu.</p> <p>Staff #10 was interviewed on 10/26/15 at 5:55 PM and indicated client C had a history of falls and staff used a gait belt to assist him.</p>	W 0153	<p>W 153 Staff Treatment of Clients The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · Training completed with the staff regarding: <ul style="list-style-type: none"> o Abuse, neglect and exploitation-what constitutes abuse, report expectations and investigation expectations (competency test provided) o When to contact the Program Coordinator · The Program Coordinator will be trained on when to contact the Program Director. · The Program Coordinator and 	12/09/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>Staff #4 was interviewed on 10/26/15 at 6:50 PM and stated client C "is hard to supervise. He has fallen recently. The meds he's on make him drowsy-when he falls it's hard to catch him." Staff #4 indicated client C had a fall risk plan to use a gait belt and a walker. Staff #4 indicated if client C falls, staff were to call the HM (house manager)/PC and indicated emergency medical services staff had to assist with client C to get up after falls twice on 10/23/15. Staff #4 indicated she not been present when client C had fallen and had been able to stop him from falling in the past by asking him to stand up straight.</p> <p>Staff #8 was interviewed on 10/27/15 at at 7:25 AM. Staff #8 indicated client C had been found on the floor of his bedroom at 3:00 AM on 10/23/15 when he was working with staff #7 on the overnight shift. He indicated client C normally got up at 4:00 AM for his shower to give him extra time. He indicated he and staff #7 had attempted to get client C up using the gait belt, but weren't able to get him up. Staff #8 indicated he had called 911 and on-call staff, and due to the emergency (with client C on the floor) the fire department had arrived to assist client C to get up. Staff #8 stated, client C "went on with his</p>		<p>Program Director will be trained on reportable incidents and notifying the administrator.</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> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · Training completed with the staff regarding: <ul style="list-style-type: none"> ○ Abuse, neglect and exploitation-what constitutes abuse, report expectations and investigation expectations (competency test provided) ○ When to contact the Program Coordinator <ul style="list-style-type: none"> · The Program Coordinator will be trained on when to contact the Program Director. · The Program Coordinator and Program Director will be trained on reportable incidents and notifying the administrator. <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"> · Training completed with the staff regarding: <ul style="list-style-type: none"> ○ Abuse, neglect and exploitation-what constitutes abuse, report expectations and investigation expectations (competency test provided) 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 11/09/2015	
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012			
(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>day and showered.</p> <p>Staff #7 was interviewed on 10/27/15 at 8:20 AM. Staff #7 stated client C was currently asleep in his room, client C was better 2-3 weeks ago and has been "like this for a week." Staff #7 indicated client C had been experiencing medication adjustments. Staff #7 indicated she had been present when client C fell on 10/23/15 on the overnight shift and at 9:00 AM. She saw client C fall as she went around the back of the van to assist with the lift. She stated staff #8 "was right in front of him. He was walking to his car to leave and was not assisting [client C]." Staff #7 indicated client C took about 30 minutes to leave the kitchen to get to the van on the morning of 10/23/15 prior to his fall and was not rushed.</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services were reviewed on 10/27/15 at 10:15 AM and included the following for client C:</p> <p>A BDDS report written by the PD dated 10/23/15 was reviewed on 10/23/15 at 12:20 PM and indicated at 9:00 AM, client C "was walking to the bus lift where his legs gave out and he fell chest first into (sic) the driveway. i (sic) evaluated him, no blood, did not loose</p>		<p>o When to contact the Program Coordinator</p> <ul style="list-style-type: none"> · The Program Coordinator will be trained on when to contact the Program Director. · The Program Coordinator and Program Director will be trained on reportable incidents and notifying the administrator. <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · New staff hired to work at the site will receive training on reportable incidents, reporting expectations and who to contact. · Quarterly Health and Safety assessments will be completed by the Program Coordinator and/or the Program Director and forwarded to the Quality Improvement department. These assessments include a review of the environmental needs for the home, review of risk plans, ISP, BSP and client specific training for the residents. The assessment also includes an interview of staff to ensure they know how to properly document medical needs, how to report incidents, diets and understanding of BSP's. · The Quality Improvement Department and the Area Director will monitor incidents as they are reported to ensure that they are reported timely and that all required incidents are reported to BDDS. <p>5. What is the date by which the systemic changes will be</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>(sic) consciousness, complained of pain in both wrist (sic), both legs, and in his face and right eye, called ambulance. [Client C] was taken to the hospital and kept for an overnight observation. Corrective action indicated "Follow Mentors (sic) policy on falls." There was no evidence the fall on 10/23/15 at 3:00 AM had been reported to the administrator or to BDDS.</p> <p>A Preliminary Report of Alleged Adult Endangerment was reviewed on 10/27/15 at 9:30 AM and indicated " On 10/26/15 APS (Adult Protective Services) received the following report: ...Please see the attached police report from [county] regarding [client C] (Victim). Victim (client C) is mentally handicapped. Victim resides in a group home believed to be under the supervision of REM-Indiana Mentor/Occazio ...According to the police report, [client C] is around 5' (feet) 10" (inches) and weighs over 300 lbs (pounds). Officer [name] states in her report that this is the second time in two weeks that she has been to the home due to Victim falling in the driveway. The first occurrence was on 10/15/15. Also Officer [name] was advised that the [township name] Fire Department was out on Victim around 4:00 (AM/PM not specified) on this date, 10/23/15 due to victim falling out of bed.</p>		<p>completed? December 9th, 2015</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>There is concern over a lack of staff or supervision at the group home to assist Victim and also inadequate equipment to accommodate Victim " An attached police report indicated a Case Narrative " On 10/23/15, I assisted with [township] Fire Department on an injured (sic) in a fall at [group home address]. This is a group home. This is the second time in 2 weeks that I have been to the group home in regards to the same client falling in the driveway. The prior incident was 10/15/15. I was advised the fire department was requested around 04:00 on 10/23/15 due to [client C] falling out of bed. I was advised the fire department assisted [client C] in standing.</p> <p>On 10/15/15, [client C] had fell (sic) in the driveway. [Client C] is approximately 5'10" and weighs over 300 pounds. The fire department assisted [client C] in standing and getting him back into a van. The fire department requested a wheelchair due to the distance the van was due to where [client C] fell. A wheelchair was brought out from the facility that would not be large enough for a large adult let alone a client that is obese as [client C]. On this occasion [client C] was unsteady on his feet and was unable to walk without assistance. The firemen had to place each of [client C 's] legs into the van. The (sic) they had</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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 push on his bottom to move him over so that the door would close. [Client C] attempted to assist but trembled as he tried to move his own weight. There was a small bus that was picking up some of the clients. It is my understanding that [client C] would have to climb the stairs in order to get on the small bus. The bus is equipped with a ramp. One of the fireman (sic) advised that someone from the group home advised that there has not had (sic) a manager for some time. They also advised that the clients are shipped from this facility to another due to being understaffed during the daytime. The staff was little to no help in getting [client C] on the van.</p> <p>There was no evidence in reports provided by the facility the incident of client C falling on October 15, 2015 and on October 23, 2015 at 3:00 AM had been reported to the administrator or BDDS.</p> <p>The Area Director (AD) was interviewed on 10/27/15 at 12:15 PM and indicated client C's falls which required the use of emergency personnel should have been reported to her and to BDDS.</p> <p>2. A BDDS report dated 5/23/15 and reported 5/28/15 indicated "staff stated that he was driving the Vehicle to drop</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>off another client at workshop. He turned a corner and rear passenger side strap failed and released tension causing the chair to fall over. Client was unharmed but needed to be picked up by three individuals because the wheelchair was heavy."</p> <p>An investigation dated 6/1/15 completed by the PD was reviewed on 10/27/15 at 11:00 AM and indicated the staff #15:</p> <p>Staff #15 indicated in an interview on 6/3/15 "that [client F] and a few others yelled at him and he said once he looked back and seen (sic) [client B] was on the ground he had to pull over. Stated the rear right hand side belt failed and released...." when staff #15 was asked why he didn't report it, "Stated he didn't report it because it just slipped his mind because he had a lot going on that weekend with his fiance being in the hospital...."</p> <p>The conclusion of the investigation indicated "Evidence supports staff did not follow protocol(s). Recommendations/Corrective Measures to Prevent the Likelihood of Future Occurrences: Staff will be retrained on and sign off on call procedures and attendance policy. Staff will be retrained on tie-downs. Staff will monitor an</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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
W 0154 Bldg. 00	<p>injury's (sic) for [client B] and report concerns immediately."</p> <p>The Area Director (AD) was interviewed on 10/27/15 at 11:35 AM and indicated the incident had not been timely reported.</p> <p>This federal tag relates to complaints #IN00175282 and #IN00185516.</p> <p>9-3-2(a) 9-3-1(b)(5)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 3 of 4 sampled clients (clients A, B and C), and for 2 additional clients (clients E and F), the facility failed to complete thorough investigations. The facility</p>	W 0154	<p>W 154 Staff Treatment of Clients The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>1. What corrective action will</p>	12/09/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>failed to investigate falls involving clients B and C. The facility failed to thoroughly investigate an incident involving client A being left alone and staff's unsafe driving. The facility failed to thoroughly investigate an allegation of abuse and neglect involving clients C, E and F.</p> <p>Findings include:</p> <p>1. The Program Coordinator (PC) was interviewed on 10/26/15 at 6:00 PM and stated client C had returned from the hospital "a couple of hours ago." He indicated client C had fallen on 10/23/15 and may have had the flu.</p> <p>Client E was interviewed on 10/26/15 at 6:30 PM and stated client C had been "pushed" by staff #8 causing his fall on 10/23/15.</p> <p>Client C was interviewed on 10/26/15 at 6:31 PM. He stated staff #8 had "pushed me as in rushed. I fell flat on my face." When asked how staff #8 rushed him, client C stated, "Hurry up, we're going to be late. We were outside and I was about to get on the bus."</p> <p>Staff #4 was interviewed on 10/26/15 at 6:50 PM and stated client C "is hard to supervise. He has fallen recently. The</p>		<p>be accomplished?</p> <ul style="list-style-type: none"> · The Program Coordinator and Program Director will be trained on reportable incidents. · The Program Director will be retrained on investigation expectations and completing thorough investigations. <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 Coordinator and Program Director will be trained on reportable incidents. · The Program Director will be retrained on investigation expectations and completing thorough investigations. <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 Coordinator and Program Director will be trained on reportable incidents. · The Program Director will be retrained on investigation expectations and completing thorough investigations. <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>meds he's on make him drowsy-when he falls it's hard to catch him." Staff #4 indicated client C had a fall risk plan to use a gait belt and a walker. Staff #4 indicated if client C falls, staff were to call the HM (house manager)/PC and indicated emergency medical services staff had to assist with client C to get up after falls twice on 10/23/15. Staff #4 indicated she not been present when client C had fallen and had been able to stop him in the past from falling by asking him to stand up straight.</p> <p>Staff #8 was interviewed on 10/27/15 at 7:25 AM and indicated he had not been trained on specific client interventions for client C, and client C had been found on the floor of his bedroom at 3:00 AM on 10/23/15 when he was working with staff #7 on the overnight shift. He indicated client C normally got up at 4:00 AM for his shower to give him extra time. He indicated he and staff #7 had attempted to get client C up using the gait belt, but weren't able to get him up. Staff #8 indicated he had called 911 and on-call staff, and due to the emergency (with client C on the floor) the fire department had arrived to assist client C to get up. Staff #8 stated, client C "went on with his day and showered. My shift was over and I was off the clock. I was walking him out and I don't know if he missed his step</p>		<ul style="list-style-type: none"> · The Quality Improvement Department and the Area Director will monitor incidents as they are reported to ensure that they are reported timely and that all required incidents are reported to BDDS. · New staff hired to work at the site will receive training on reportable incidents, reporting expectations and who to contact. · All abuse and neglect investigations will be reviewed by the Quality Improvement Specialist or her designee to ensure the investigations are thorough. · All investigations that are not considered abuse and neglect will be reviewed by the Area Director or her designee to ensure the investigations are thorough. <p>5. What is the date by which the systemic changes will be completed? December 9th, 2015</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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 driveway) or missed his footing, and I tried to stop it (fall). He's a pretty good sized guy-my size and just the momentum...we called 911 and then the HM (house manager)/PC. I told the HM I could leave, staff were here with him. I don't know what happened as I left. I normally clock out at 8:00 AM, it was after that."</p> <p>Staff #7 was interviewed on 10/27/15 at 8:20 AM. Staff #7 stated client C was currently asleep in his room, client C was better 2-3 weeks ago and has been "like this for a week." Staff #7 indicated client C had been experiencing medication adjustments. Staff #7 indicated she had been present when client C fell on 10/23/15 on the overnight shift and at 9:00 AM. She saw client C fall as she went around the back of the van to assist with the lift. She stated staff #8 "was right in front of him. He was walking to his car to leave and was not assisting [client C]." Staff #7 indicated client C took about 30 minutes to leave the kitchen to get to the van on the morning of 10/23/15 prior to his fall and was not rushed.</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services were reviewed on 10/27/15 at 10:15 AM and included the following for client C:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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 10/7/15 indicated on 10/7/15 at 7:10 PM, client C was found by the staff on the bedroom floor, "staff tried to help [client C] up, other client (unspecified) called ambulance, ambulance came and helped [client C] up, there appears to be no injury, but staff will continue to check throughout the shift." Corrective action indicated "Follow Mentors (sic) policy and Procedure on Falls."</p> <p>A BDDS report written by the PD dated 10/23/15 was reviewed on 10/23/15 at 12:20 PM and indicated at 9:00 AM, client C "was walking to the bus lift where his legs gave out and he fell chest first into (sic) the driveway. i (sic) evaluated him, no blood, did not loose (sic) consciousness, complained of pain in both wrist (sic), both legs, and in his face and right eye, called ambulance. [Client C] was taken to the hospital and kept for an overnight observation. Corrective action indicated "Follow Mentors (sic) policy on falls."</p> <p>An investigation into the incident on 10/23/15 dated 10/24/15 was reviewed on 10/27/15 at 12:20 PM and indicated the same information as provided in the BDDS report in regards to the incident. Staff #7, client C and the PC were</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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 as part of the investigation. Staff #7 indicated in her interview she was in the process of taking the clients out to the bus so they could go to day services. The interview indicated staff #7 stated "Everything was fine until [client C] just fell all of a sudden, [client C] told her his legs just give (sic) out and they don't want to work right sometimes, he was complaining about his wrist and legs hurting and that she called the Ambulance, the PC just pulled up." The PC indicated he had just pulled up to the group home and found that client C had just fallen. The PC indicated he went with client C to the hospital and the nurse wanted to keep client C overnight to run tests. Client C was interviewed and stated, "he was walking to the bus and his legs just gave out on him, his legs stops (sic) working from time to time and he was in some pain and wanted to go to the hospital." There was no evidence any other clients present were interviewed as part of the investigation into client C's fall on the driveway at 9:00 AM on 10/23/15.</p> <p>A Preliminary Report of Alleged Adult Endangerment was reviewed on 10/28/15 at 9:30 AM and indicated "...On 10/26/15 APS (Adult Protective Services) received the following report: ...Please see the attached police report</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>from [county] regarding [client C] (Victim). Victim (client C) is mentally handicapped. Victim resides in a group home believed to be under the supervision of REM-Indiana Mentor/Occazio ...According to the police report, [client C] is around 5' (feet) 10" (inches) and weighs over 300 lbs (pounds). Officer [name] states in her report that this is the second time in two weeks that she has been to the home due to Victim falling in the driveway. The first occurrence was on 10/15/15. Also Officer [name] was advised that the [township name] Fire Department was out on Victim around 4:00 (AM/PM not specified) on this date, 10/23/15 due to victim falling out of bed. There is concern over a lack of staff or supervision at the group home to assist Victim and also inadequate equipment to accommodate Victim " An attached police report indicated a Case Narrative " On 10/23/15, I assisted with [township] Fire Department on an injured (sic) in a fall at [group home address]. This is a group home. This is the second time in 2 weeks that I have been to the group home in regards to the same client falling in the driveway. The prior incident was 10/15/15. I was advised the fire department was requested around 04:00 on 10/23/15 due to [client C] falling out of bed. I was advised the fire department</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>assisted [client C] in standing.</p> <p>On 10/15/15, [client C] had fell (sic) in the driveway. [Client C] is approximately 5'10" and weighs over 300 pounds. The fire department assisted [client C] in standing and getting him back into a van. The fire department requested a wheelchair due to the distance the van was due to where [client C] fell. A wheelchair was brought out from the facility that would not be large enough for a large adult let alone a client that is obese as [client C]. On this occasion [client C] was unsteady on his feet and was unable to walk without assistance. The fireman had to place each of [client C 's] legs into the van. The (sic) they had to push on his bottom to move him over so that the door would close. [Client C] attempted to assist but trembled as he tried to move his own weight. There was a small bus that was picking up some of the clients. It is my understanding that [client C] would have to climb the stairs in order to get on the small bus. The bus is equipped with a ramp. One of the fireman (sic) advised that someone from the group home advised that there has not had (sic) a manager for some time. They also advised that the clients are shipped from this facility to another due to being understaffed during the daytime. The staff was little to no help in getting</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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 C] on the van.</p> <p>There was no evidence in reports provided by the facility the incident of client C falling on October 15, 2015 and on 10/23/15 at 4:00 AM had been investigated.</p> <p>The Area Director (AD) was interviewed on 10/27/15 at 12:20 PM and indicated any clients present should have been interviewed as part of the investigation completed by the Program Director (PD) into the incident of client C falls on 10/23/15. She indicated there was no evidence the fall on 10/23/15 at 4:00 AM had been reported or investigated. The AD indicated she was unaware of a fall requiring the use of emergency personnel on 10/15/15 and it had not been reported to her or investigated.</p> <p>2. A BDDS report dated 5/23/15 and reported 5/28/15 indicated "staff stated that he was driving the Vehicle to drop off another client at workshop. He turned a corner and rear passenger side strap failed and released tension causing the chair to fall over. Client B was unharmed but needed to be picked up by three individuals because the wheelchair was heavy." Corrective action indicated "Retrain Staff on reporting incident, bus safety, as well as contact PC or PD as</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>soon as accident happens.</p> <p>An investigation dated 6/1/15 completed by the PD was reviewed on 10/27/15 at 11:00 AM and indicated the following interviews with clients A, E, F and B and by staff #15:</p> <p>Client E indicated in an interview on 6/2/15 he saw client B fall over on his side and "he had to yell at [staff #15] twice to stop the bus because [client B] was over on his side...stated that he said something to him (unspecified) about the straps being put on correctly (sic) he also stated that [staff #15], [client F] and himself had to lift [client B] off the ground. Stated that the music was up a little loud and that's why he had to yell twice at [staff #15] to get his attention to stop the bus."</p> <p>Client B indicated in an interview on 6/2/15 "stated that he felt like [staff #15] was driving fast on that day. Stated that he felt his straps was (sic) not put on correctly and said that [client E] said something to [staff #15] about the straps not being on right. [Client B] stated that he (unspecified) had the radio loud and couldn't hear him. [Client B] stated that he was telling [staff #15] he was falling over and presumed to turn up the radio. Stated that once he fell over [client E]</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>yelled at [staff #15] to stop the bus. [Client B] stated that [client E] tried to pick him up but was too heavy and by that time [client F] and [staff #15] was (sic) helping lift him."</p> <p>Client A indicated in an interview on 6/2/15 "they had to call [staff #15] a few times to get his attention," and indicated staff #15, and clients E and F assisted client B up off the ground and secured the straps.</p> <p>Client F indicated in an interview on 6/2/15 client E had to call staff #15 twice to get his attention after client B fell over before staff #15 stopped to get client B up and secure the tie downs to his wheelchair before driving client A to work.</p> <p>Staff #15 indicated in an interview on 6/3/15 "that [client F] and a few others yelled at him and he said once he looked back and seen (sic) [client B] was on the ground he had to pull over. Stated the rear right hand side belt failed and released...."</p> <p>The conclusion of the investigation indicated "Evidence supports staff did not follow protocol(s). Recommendations/Corrective Measures to Prevent the Likelihood of Future</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>Occurrences: Staff will be retrained on and sign off on call procedures and attendance policy. Staff will be retrained on tie-downs. Staff will monitor an injury's (sic) for [client B] and report concerns immediately." There was no evidence staff #15's fast driving or driving with the music on so loud he was unable to hear clients yelling when client B fell was addressed as part of the investigation.</p> <p>The Area Director (AD) was interviewed on 10/27/15 at 11:35 AM and indicated the investigation should have addressed the client's statements about staff #15 driving fast and having the music on so loud he could not hear them yelling when client B fell over in his wheelchair.</p> <p>3. A BDDS report dated 6/6/15 at 10:23 PM indicated "[Client A] and [Client I] were on an outing with [staff #15] and upon arriving back home the other staff working [staff #6] seen (sic) that something was wrong with [staff #15]. It was reported to [staff #6] that [staff #15] took [client A] and [client I] on a location not approved by the PD or PC. It was report (sic) to [staff #6] that [client A] and [client I] may have been left in the van up to 30 minutes unintended (sic). It was reported that [staff #15] was suspected to be under the influence of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>something and was found in the living room asleep on the couch. Upon reciving (sic) these concerns [staff #6] contacted the on call PC and the on call PC informed the PD and the PD went to the home and found [staff #15] sleep (sic). PD suspended [staff #15] immediately and sent him home. PD checked to make sure everyone in the house was safe. PD also was in contact with other home manager for [client I] to inform them of the situation and ensure [client I's] safety. There was (sic) no injuries observed and reported." Corrective action indicated "Staff has been suspended upon completion of (sic) investigation."</p> <p>A Summary of Internal Investigation Report dated 6/10/15 was reviewed on 10/27/15 at 10:40 AM and failed to indicate client I had been interviewed as part of the investigation. An undated interview with client A indicated he and client I were taken to a restaurant for about 30 minutes and then went to the house where they have never been before. "Said [staff #15] left them in the car for 30 minutes while he was in the house. Said on the way home he was scared because [staff #15] hit a median and almost hit another car...."</p> <p>The Area Director (AD) was interviewed on 10/27/15 at 11:35 AM and indicated</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>staff #15 had been terminated after the incident on 6/6/15 involving client A and there was no evidence client I had been interviewed as part of the investigation.</p> <p>3. Observations were completed at the group home on 10/26/15 from 5:55 PM until 7:06 PM. Client C sat on his bed and asked staff #7 to assist him in removing his hospital bracelets, with the exception of the bracelet labeled "fall risk," which he wanted to remain attached to his wrist.</p> <p>The Program Coordinator (PC) was interviewed on 10/26/15 at 6:00 PM and stated client C had returned from the hospital "a couple of hours ago." He indicated client C had fallen on 10/23/15 and may have had the flu.</p> <p>Client E was interviewed on 10/26/15 at 6:30 PM and stated staff #8 "Is demanding. I know this is our house, but I feel like it's not our house." Client E stated client C had been "pushed" by staff #8 causing his fall on 10/23/15.</p> <p>Client C was interviewed on 10/26/15 at 6:31 PM. He stated staff #8 had "pushed me as in rushed. I fell flat on my face." When asked how staff #8 rushed him, client C stated, "Hurry up, we're going to be late. We were outside and I was about</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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 get on the bus."</p> <p>Client F was interviewed on 10/26/15 at 6:20 PM and stated staff #8 "bosses me around," and staff #8 would tell client F to "Get this done." When asked if he had informed anyone, he indicated he had told the PC (Program Coordinator) who was standing in the area.</p> <p>The PC was interviewed on 10/26/15 at 6:20 PM and indicated he had been made aware of clients E and F's concerns of staff #8's approach earlier that week (date not specified) and was going to address it with staff #8.</p> <p>Staff #4 was interviewed on 10/27/15 at 7:40 AM and stated she had heard clients complain about staff #8 "bossing" clients. She indicated staff #8 was sometimes directive in requests and she had attempted to demonstrate how to ask clients to complete tasks by asking them "Could you please?"</p> <p>The Area Director (AD) was interviewed on 10/27/15 at 12:20 PM and indicated staff #8 was currently suspended due to an allegation made by client F that morning of misconduct.</p> <p>A Summary of Internal Investigation Report dated 11/4/15 for an incident</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>dated 10/29/15 indicated on 10/29/15, the AD suspended staff #8 for "being bossy." The following interviews were completed as part of the investigation:</p> <p>Client C was interviewed (undated) and indicated he was walking to the bus and "his legs just gave out on him ([client C] fell going to the van on 10/29/15...Stated he felt rushed because [staff #8] was telling everyone to hurry up...Stated he doesn't like [staff #8] because he wakes me up on (sic) the morning and doesn't wake everyone else up on the morning. Stated he feels like this is [staff #8] being bossy. States an example of [staff #8] being bossy is 'Pushy, meaning talking to me real fast, telling me to hurry up. Stated [staff #8] has only been bossy on the day he [client C] fell when he had the walker...."</p> <p>Client B's undated interview indicated staff #8 was not bossy to him, but "sometimes [staff #8] is bossy to [client H]."</p> <p>Client E's undated interview indicated "things are not going good because [staff #8] is irritating...Stated he doesn't like the way [staff #8] 'speaks to them and he feels like he's in the military. Stated [staff #8] is bossy to everybody. Stated [staff</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>#8] has yelled at him and raised his voice but could not give specifics...."</p> <p>Client F's undated interview indicated " things are not going good because of [staff #8]. Stated [staff #8] is bossy. Stated [staff #8] will go into his bedroom and hook his phone up to the surround sound in my bedroom. Stated he wants to get rid of [staff #8]. " Staff #8 " demands " client F to wash the table as part of his assigned chores and staff #8 has yelled at him and raised his voice. When asked if [staff #8] has been physically abusive towards him states, 'yes, he punches his hand. ' "</p> <p>Staff #4 s undated interview indicated "she had never seen [staff #8] be bossy towards clients."</p> <p>The PD's undated interview indicated he had interviewed clients G, E and H. The interview indicated the clients did not think staff #8 raised his voice, and staff #8 "just tells them what to do," and client H did not like to get up at 5:00 AM when staff #8 woke him up with the other clients. The PD "Stated the clients he spoke to said if a female were to ask in the same manner and tone as [staff #8] it would not be a problem. "</p> <p>Staff #8's undated interview indicated</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>staff #8 "Just wakes them up and lets them know from time to time they are running behind, but he has never been bossy or mean to them.</p> <p>The conclusion indicated "evidence does not support the allegation of verbal abuse from [client F] involving [staff #8], and [staff #8] will be retrained on how to speak to clients."</p> <p>The AD (Area Director) was interviewed on 11/9/15 at 4:35 PM and indicated the investigation did not address client F' s allegation staff #8 hit his hand or the discrepancies between the statements of clients C, E and F and the PD.</p> <p>This federal tag relates to complaints #IN00175282 and #IN00185516.</p> <p>9-3-2(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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
W 0157 Bldg. 00	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on observation, record review and interview for 3 of 4 sampled clients (clients A, B, and C) , the facility failed to develop and implement effective corrective action to protect client C from falls after a history of falls was identified. The facility failed to protect client B from his wheelchair falling over during transport as a result of improper securing of his wheelchair, and failed to provide supervision and protect client A from impaired/unsafe driving by the same staff who failed to secure the wheelchair properly. The facility failed to implement effective corrective action to address the staff's unsafe driving habits after they had been identified in an investigation.</p> <p>Findings include:</p> <p>1. Observations were completed at the group home on 10/26/15 from 5:55 PM until 7:06 PM. Client C sat on his bed and asked staff #7 to assist him in removing his hospital bracelets, with the</p>	W 0157	<p>W 157 Staff Treatment of Clients If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: <ul style="list-style-type: none"> o Abuse, neglect and exploitation-what constitutes abuse, report expectations and investigation expectations (competency test provided) o When to contact the Program Coordinator o How to properly secure a wheelchair in the bus using the wheelchair tie downs for Client B o Training regarding the risk plans 	12/09/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>exception of the bracelet labeled "fall risk," which he wanted to remain attached to his wrist.</p> <p>The Program Coordinator (PC) was interviewed on 10/26/15 at 6:00 PM and stated client C had returned from the hospital "a couple of hours ago." He indicated client C had fallen on 10/23/15 and may have had the flu.</p> <p>Staff #10 was interviewed on 10/26/15 at 5:55 PM and indicated client C had a history of falls and staff used a gait belt to assist him.</p> <p>Client E was interviewed on 10/26/15 at 6:30 PM and stated client C had been "pushed" by staff #8 causing his fall on 10/23/15.</p> <p>Client C was interviewed on 10/26/15 at 6:31 PM. He stated staff #8 had "pushed me as in rushed. I fell flat on my face." When asked how staff #8 rushed him, client C stated, "Hurry up, we're going to be late. We were outside and I was about to get on the bus."</p> <p>Staff #4 was interviewed on 10/26/15 at 6:50 PM and stated client C "is hard to supervise. He has fallen recently. The meds he's on make him drowsy-when he falls it's hard to catch him." Staff #4</p>		<p>and health needs for Clients C.</p> <ul style="list-style-type: none"> o Review the supervision needs for Client A o Vehicle use and safe driving training <ul style="list-style-type: none"> · The Program Coordinator and Program Director will be retrained on the appointment process expectations, following physician recommendations and communication expectations with the nurse. · The Program Coordinator and Program Director will be retrained on implementing corrective actions to address staff performance concerns and regarding recommendations made from investigations. · The new nurse will be at the site weekly to help oversee the medical needs of the residents and complete assessments as needed. · The IDT is currently meeting weekly to address Client C's health care needs. The IDT will continue to monitor his needs and may change the need to meet weekly as his health care needs improve and/or stabilize. · Client C has been participating in Physical Therapy services within the home. · Client C now has a walker, patient lift, gait belt, mat for his floor, audible monitor, motion alarm, bed rails and a wheelchair to assist in preventing falls. · Client C has had one on one supervision to assist in fall prevention. The IDT continues to monitor the need for this level of 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>indicated client C had a fall risk plan to use a gait belt and a walker. Staff #4 indicated if client C falls, staff were to call the HM (house manager)/PC and indicated emergency medical services staff had to assist with client C to get up after falls twice on 10/23/15. Staff #4 indicated she not been present when client C had fallen and had been able to stop him from falling in the past by asking him to stand up straight.</p> <p>Observations were completed again at the group home on 10/27/15 from 7:10 AM until 8:38 AM. Staff #8 assisted client C to get up from his bed using a gait belt. Client C used a rolling walker to go to the kitchen and sat on a wooden kitchen chair. Staff #8 and #9 assisted client C to get up from the chair using a gait belt and to use his walker. Staff #9 showed staff #8 how to position the gait belt for client C and how to position client C to his walker to aid him in rising from the chair. Client C requested a wooden chair to sit on in the living room and sat on the chair without arms with his head slumped toward his chest and his eyes closed. Client C's color was pale and of a yellow tint, and he aroused and indicated he was tired. Staff #9 assisted client C using a gait belt and asked him to count to 3 and stand using his walker. Client C stood up and used his walker to walk to his room.</p>		<p>supervision to continue. The IDT will make recommendations for this supervision to change as his health care needs improve and/or stabilize.</p> <ul style="list-style-type: none"> · Client C will participate in programming to help him understand the need to use his adaptive equipment and to complete his physical therapy exercises. · Client C now has a C-pap machine in place. · Client C is participating in 15 minute checks throughout the night to monitor the use of his C-pap machine. · Client C was seen by his psychiatrist on 10-29-15 to monitor his psych needs. He will see the psychiatrist again in January or sooner if needed. · Client C continues to see his counselor to help address his mental health needs. · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · Daily nursing oversight for Client C was completed through 11-24-15. · Currently the nurse is assessing Client C three times a week. The IDT will continue to monitor the need for this level of supervision to continue. The IDT will make recommendations for this supervision to change as his health 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 11/09/2015
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012		
(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>Staff #9 instructed client C to keep his walker close to him while he walked for stability and to assist him in standing straighter and complimented him on his ability to stand.</p> <p>Staff #8 and #9 were interviewed on 10/27/15 at 7:25 AM. Staff #9 indicated she was a CNA (certified nursing assistant).</p> <p>Staff #8 indicated he had not been trained on specific client interventions for client C, and client C had been found on the floor of his bedroom at 3:00 AM on 10/23/15 when he was working with staff #7 on the overnight shift. He indicated client C normally got up at 4:00 AM for his shower to give him extra time. He indicated he and staff #7 had attempted to get client C up using the gait belt, but weren't able to get him up. Staff #8 indicated he had called 911 and on-call staff, and due to the emergency (with client C on the floor) the fire department had arrived to assist client C to get up. Staff #8 stated, client C "went on with his day and showered. My shift was over and I was off the clock. I was walking him out and I don't know if he missed his step (on the driveway) or missed his footing, and I tried to stop it (fall). He's a pretty good sized guy-my size and just the momentum...we called 911 and then the</p>		<p>care needs improve and/or stabilize.</p> <ul style="list-style-type: none"> · Client C's risk plans will be reviewed by the nurse. Revisions will be implemented as necessary. · The nurse will be trained on how to follow up with physician recommendations to ensure they are implemented and/or addressed by the IDT. · Competency training with the nurse was completed with staff on 10-28 and 10-29-15 which included one person transfers, two person transfers, use of a gait belt, wheelchair safety, and one person assist. · Training was completed by the nurse on 10-29-15 included body mechanics/safe transfers, updated fall risk plan for Client C, adaptive equipment and change in health status reporting. · The nurse will monitor staff documentation at a minimum of weekly and communicate with the necessary team members as needed. · The nurse will conduct quarterly staff observations to ensure continued competency over adaptive equipment, body mechanics/safe transfers. · Client Specific training for new staff will include body mechanics/safe transfers and the use of a gait belt. · The Program Coordinator will check adaptive equipment weekly to ensure compliance. · Client C's ISP will be updated to reflect his current needs. · The IDT will monitor trends 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>HM (house manager)/PC. I told the HM I could leave, staff were here with him. I don't know what happened as I left. I normally clock out at 8:00 AM, it was after that."</p> <p>Staff #7 was interviewed on 10/27/15 at 8:20 AM. Staff #7 stated client C was currently asleep in his room, client C was better 2-3 weeks ago and has been "like this for a week." Staff #7 indicated client C had been experiencing medication adjustments. Staff #7 indicated she had been present when client C fell on 10/23/15 on the overnight shift and at 9:00 AM. She saw client C fall as she went around the back of the van to assist with the lift. She stated staff #8 "was right in front of him. He was walking to his car to leave and was not assisting [client C]." Staff #7 indicated client C took about 30 minutes to leave the kitchen to get to the van on the morning of 10/23/15 prior to his fall and was not rushed. She indicated she had not received client specific training for client C to assist him using the gait belt or address his falls.</p> <p>Client C's discharge orders from the hospital were reviewed on 10/26/15 at 6:28 PM. The discharge orders indicated client C's clonazepam was reduced to 5 mg (milligrams) from 10 mg. There was</p>		<p>and patterns in client reportable incidents. The IDT will convene as necessary to discuss an increase in reportable incidents such as falls.</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> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: <ul style="list-style-type: none"> o Abuse, neglect and exploitation-what constitutes abuse, report expectations and investigation expectations (competency test provided) o When to contact the Program Coordinator o How to properly secure a wheelchair in the bus using the wheelchair tie downs for Client B o Training regarding the risk plans and health needs for Clients C. o Vehicle use and safe driving training · The Program Coordinator and Program Director will be retrained 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>no other information in regards to client C's diagnosis or instructions to address client C's follow up care.</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services were reviewed on 10/27/15 at 10:15 AM and included the following for client C:</p> <p>A BDDS report dated 5/8/15 indicated on 5/8/15 at 6:25 AM, client C fell during his shower. Staff reported client C bruised his bottom (size and specific location not indicated). Client C later stated, "that he may have hit his head when falling. PC (Program Coordinator) contacted the nurse consultant and was advised to take [client C] to the ER (emergency room). Corrective action indicated the PC would follow recommendations of (sic) nurse consultant and ER physician. Staff will continue to monitor for any changes and report concerns immediately."</p> <p>A BDDS report dated 10/3/15 indicated client C "was having chest pains and thought he was having a heart attack so staff called the ambulance were (sic) he was taken to the hospital and treated. Hospital stated he was having an (sic) just pains and gave him tylenol. Hospital staff stated if chest pain continues after 3 to 4 days then go see his doctor."</p>		<p>on the appointment process expectations, following physician recommendations and communication expectations with the nurse.</p> <ul style="list-style-type: none"> · The Program Coordinator and Program Director will be retrained on implementing corrective actions to address staff performance concerns and regarding recommendations made from investigations. · The new nurse will be at the site weekly to help oversee the medical needs of the residents and complete assessments as needed. · The IDT will continue to monitor the needs of all of the clients. The IDT will convene to address and monitor the health care needs of the residents until they improve and/or stabilize. · The need for adaptive equipment for the residents will be reviewed. In the event that additional adaptive equipment is needed the IDT will obtain it per physician recommendations. · The Program Director/QIDP will review all ISP's to ensure that they are updated and completed on a yearly basis or more frequently as the needs arise. · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/09/2015	
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012			
(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>Corrective action indicated "Staff will continue to follow mentor (sic) policy as stated."</p> <p>A BDDS report dated 10/7/15 indicated on 10/7/15 at 7:10 PM, client C was found by the staff on the bedroom floor, "staff tried to help [client C] up, other client (unspecified) called ambulance, ambulance came and helped [client C] up, there appears to be no injury, but staff will continue to check throughout the shift." Corrective action indicated "Follow Mentors (sic) policy and Procedure on Falls."</p> <p>A BDDS report written by the PD dated 10/23/15 was reviewed on 10/23/15 at 12:20 PM and indicated at 9:00 AM, client C "was walking to the bus lift where his legs gave out and he fell chest first into (sic) the driveway. i (sic) evaluated him, no blood, did not loose (sic) consciousness, complained of pain in both wrist (sic), both legs, and in his face and right eye, called ambulance. [Client C] was taken to the hospital and kept for an overnight observation. Corrective action indicated "Follow Mentors (sic) policy on falls."</p> <p>An investigation into the incident on 10/23/15 dated 10/24/15 was reviewed on 10/27/15 at 12:20 PM and indicated the</p>		<ul style="list-style-type: none"> · All resident risk plans will be reviewed by the nurse. Revisions will be implemented as necessary. · The nurse will be trained on how to follow up with physician recommendations to ensure they are implemented and/or addressed by the IDT. · Competency training with the nurse was completed with staff on 10-28 and 10-29-15 which included one person transfers, two person transfers, use of a gait belt, wheelchair safety, and one person assist. · Training was completed by the nurse on 10-29-15 included body mechanics/safe transfers, updated fall risk plan for Client C, adaptive equipment and change in health status reporting. · The nurse will monitor staff documentation at a minimum of weekly and communicate with the necessary team members as needed. · The nurse will conduct quarterly staff observations to ensure continued competency over adaptive equipment, body mechanics/safe transfers. · Client Specific training for new staff will include body mechanics/safe transfers and the use of a gait belt. · The Program Coordinator will check adaptive equipment weekly to ensure compliance. · The IDT will monitor trends and patterns in client reportable incidents. The IDT will convene as necessary to discuss an increase in 				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>same information as provided in the BDDS report in regards to the incident. Staff #7, client C and the PC were interviewed as part of the investigation. Staff #7 indicated in her interview she was in the process of taking the clients out to the bus so they could go to day services. The interview indicated staff #7 stated "Everything was fine until [client C] just fell all of a sudden, [client C] told her his legs just give (sic) out and they don't want to work right sometimes, he was complaining about his wrist and legs hurting and that she called the Ambulance, the PC just pulled up." The PC indicated he had just pulled up to the group home and found that client C had just fallen. The PC indicated he went with client C to the hospital and the nurse wanted to keep client C overnight to run tests. Client C was interviewed and stated, "he was walking to the bus and his legs just gave out on him, his legs stops (sic) working from time to time and he was in some pain and wanted to go to the hospital."</p> <p>A Preliminary Report of Alleged Adult Endangerment was reviewed on 10/28/15 at 9:30 AM and indicated " On 10/26/15 APS (Adult Protective Services) received the following report: ...Please see the attached police report from [county] regarding [client C] (Victim). Victim</p>		<p>reportable incidents such as falls.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: <ul style="list-style-type: none"> o Abuse, neglect and exploitation-what constitutes abuse, report expectations and investigation expectations (competency test provided) o When to contact the Program Coordinator o How to properly secure a wheelchair in the bus using the wheelchair tie downs for Client B o Training regarding the risk plans and health needs for Clients C. o Vehicle use and safe driving training · The Program Coordinator and Program Director will be retrained on the appointment process expectations, following physician recommendations and communication expectations with the nurse. · The Program Coordinator and 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(client C) is mentally handicapped. Victim resides in a group home believed to be under the supervision of REM-Indiana Mentor/Occazio ...According to the police report, [client C] is around 5' (feet) 10" (inches) and weighs over 300 lbs (pounds). Officer [name] states in her report that this is the second time in two weeks that she has been to the home due to Victim falling in the driveway. The first occurrence was on 10/15/15. Also Officer [name] was advised that the [township name] Fire Department was out on Victim around 4:00 (AM/PM not specified) on this date, 10/23/15 due to victim falling out of bed. There is concern over a lack of staff or supervision at the group home to assist Victim and also inadequate equipment to accommodate Victim " An attached police report indicated a Case Narrative " On 10/23/15, I assisted with [township] Fire Department on an injured (sic) in a fall at [group home address]. This is a group home. This is the second time in 2 weeks that I have been to the group home in regards to the same client falling in the driveway. The prior incident was 10/15/15. I was advised the fire department was requested around 04:00 on 10/23/15 due to [client C] falling out of bed. I was advised the fire department assisted [client C] in standing.		Program Director will be retrained on implementing corrective actions to address staff performance concerns and regarding recommendations made from investigations. <ul style="list-style-type: none"> · The new nurse will be at the site weekly to help oversee the medical needs of the residents and complete assessments as needed. · The IDT will continue to monitor the needs of all of the clients. The IDT will convene to address and monitor the health care needs of the residents until they improve and/or stabilize. · The need for adaptive equipment for the residents will be reviewed. In the event that additional adaptive equipment is needed the IDT will obtain it per physician recommendations. · The Program Director/QIDP will review all ISP's to ensure that they are updated and completed on a yearly basis or more frequently as the needs arise. · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · All resident risk plans will be reviewed by the nurse. Revisions will be implemented as necessary. · The nurse will be trained on how to follow up with physician recommendations to ensure they are 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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 10/15/15, [client C] had fell (sic) in the driveway. [Client C] is approximately 5'10" and weighs over 300 pounds. The fire department assisted [client C] in standing and getting him back into a van. The fire department requested a wheelchair due to the distance the van was due to where [client C] fell. A wheelchair was brought out from the facility that would not be large enough for a large adult let alone a client that is obese as [client C]. On this occasion [client C] was unsteady on his feet and was unable to walk without assistance. The fireman had to place each of [client C 's] legs into the van. The (sic) they had to push on his bottom to move him over so that the door would close. [Client C] attempted to assist but trembled as he tried to move his own weight. There was a small bus that was picking up some of the clients. It is my understanding that [client C] would have to climb the stairs in order to get on the small bus. The bus is equipped with a ramp. One of the fireman (sic) advised that someone from the group home advised that there has not had (sic) a manager for some time. They also advised that the clients are shipped from this facility to another due to being understaffed during the daytime. The staff was little to no help in getting [client C] on the van.</p>		<p>implemented and/or addressed by the IDT.</p> <ul style="list-style-type: none"> · Competency training with the nurse was completed with staff on 10-28 and 10-29-15 which included one person transfers, two person transfers, use of a gait belt, wheelchair safety, and one person assist. · Training was completed by the nurse on 10-29-15 included body mechanics/safe transfers, updated fall risk plan for Client C, adaptive equipment and change in health status reporting. · The nurse will monitor staff documentation at a minimum of weekly and communicate with the necessary team members as needed. · The nurse will conduct quarterly staff observations to ensure continued competency over adaptive equipment, body mechanics/safe transfers. · Client Specific training for new staff will include body mechanics/safe transfers and the use of a gait belt. · The Program Coordinator will check adaptive equipment weekly to ensure compliance. · The IDT will monitor trends and patterns in client reportable incidents. The IDT will convene as necessary to discuss an increase in reportable incidents such as falls. <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 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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 10/23/15, [client C] was lying face down on the driveway, which is a slight decline. His face was toward the downward slope and facing opposite of the house. [Client C] had a blanket draped over him, but he was shaking. I spoke to [client C] and he complained of pain to his head. There was no blood or obvious injuries that I could see. [Client C] stated the staff tell him it is his fault that he falls because he gets in too big of a hurry. A walker was close to [client C]. One of the fire personnel advised the walker appeared to be too small for the size of [client C].</p> <p>I overheard one of the staff say his medication was changed and there should be improvements.</p> <p>The concern in if the equipment for [client C] is adequate for his size, as well as if there is adequate staff to deal with [client C ' s] needs. [Client C] is a mentally disabled individual and may not be able to adequately express his needs or provide for himself to attain what he needs. " There was a note at the bottom of the report "Forward to Adult Protective Services. "</p> <p>There was no evidence in reports provided by the facility the incident of client C falling on October 15, 2015 had</p>		<p>monitor to ensure the clients plans and needs are being met during their bi-weekly observations.</p> <ul style="list-style-type: none"> · The Program Coordinator will monitor to ensure the clients plans and needs are being met during their weekly observations. · Mentor's nurse will be in the home on a weekly basis or more frequently as needed to monitor for concerns and assess residents. · New staff hired to work at the site will receive client specific training for each individual prior to working a shift. This training includes items such as: client's diets, risk plans, ISP's, programming, and medication review. · The nurse will be available to do observations within the home for medical related issues as the client's needs indicate. · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · The QIDP will monitor and review the resident's needs. As the needs arise, formal programming will be implemented. · Quarterly Health and Safety assessments will be completed by the Program Coordinator and/or the Program Director and forwarded to the Quality Improvement department. These assessments include a review of the environmental needs for the 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/09/2015	
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012			
(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>been reported to the administrator, BDDS, investigated or of corrective action taken to address client C' s fall.</p> <p>The Area Director (AD) was interviewed on 10/27/15 at 12:15 PM and indicated client C's falls which required the use of emergency personnel should have been reported to her and to BDDS so they could be addressed.</p> <p>Client C's record was reviewed on 10/27/15 at 12:55 PM. A visit to client C's primary care physician dated 9/14/15 indicated client C weighed 333.9 pounds in 4/15. There were no other records found to indicate client C's weight. There was no evidence of an updated Individual Support Plan since his last ISP dated 3/4/15.</p> <p>A Risk Plan updated on 10/27/15 and previously updated on 10/14/11 indicated client C's risks included, but were not limited to medication side effects, depression, Intermittent Explosive Disorder, Personality Disorder, Obesity, Phlebitis (blood clots), warfarin (blood thinner/anti-coagulant) therapy, and history of falls. Client C's risk for warfarin therapy indicated "Warfarin can cause very serious (possibly fatal) bleeding." Client C's falls risk indicated he "has a history of falls and at risk for</p>		<p>home, review of risk plans, ISP, BSP and client specific training for the residents. The assessment also includes an interview of staff to ensure they know how to properly document medical needs, how to report incidents, diets and understanding of BSP's.</p> <p>Corrective actions taken by the Program Coordinator and the Program Director will be turned into the HR department, the Area Director and/or the Quality Improvement Specialist (as deemed appropriate to each individual) to ensure that the corrective actions are implemented per investigation recommendations.</p> <p>5. What is the date by which the systemic changes will be completed? December 9th, 2015</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>falls. [Client C] is to be using w/c (wheelchair) and gait belt PRN (as needed) for increased unsteady gait. Staff are to ensure environment free from fall hazards (rugs, cords, etc), if fall occurs assessment to be completed and PC/PD to be phoned regarding fall. If (sic) sustains injury that appears severe/life threatening in nature, they are to initiate EMS (emergency medical services) prior to notification of PC/PD. Obtain vitals and document accordingly." The plan failed to indicate how many staff were to assist client C in using the gait belt, transferring or specific information as to when client C was to use the wheelchair and gait belt and how staff were to assist him with the adaptive equipment. The plan failed to indicate the use of client C's rolling walker.</p> <p>IDT (interdisciplinary) meeting notes on 10/16/15 in client C's record entered by the Behavior Analyst (BA) indicated client C "has been observed falling asleep, having difficulty walking, standing, getting out of bed." The note indicated client C's psychiatrist nurse practitioner (NP) had "increased Seroquel (anti-psychotic) from 400 mg (milligrams) daily to 400 mg BID (twice daily), changed Depakote (seizures/mood stability) from 2,000 mg at bedtime to 1,000 mg BID, changed Clonazepam</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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
	(anxiety) from 1 mg BID to 1 mg TID (three times daily), added Zyprexa Zydys 5 mg PRN (as needed) for agitation on September 16, 2015. After med (medication) change, staff nurse, [name] stated [client C] had increased his falls over the weekend and contacted [client C's] [primary care physician (PCP)] to request a med decrease of Seroquel. [PCP], decreased Seroquel back to 400 mg daily-other psych med changes made by [NP] were continued. Even after dosage change of Seroquel, [client C] displays frequent difficulty ambulating requiring the fire department to be contacted three times during the month of October to assist staff in helping [client C] get up/ambulate. [Client C] has also been taken to the ER twice since his admission due to reports he was having a heart attack on one occasion and reports he was having difficulty walking on the second occasion-no medical confirmation was made at either ER visit. [Client C] had some med changes that occurred at the nursing home prior to his admission to the group home on September 11, 2015. Said changes that included Provigil discontinued and Keppra added. [Client C] has completed labs to check Depakote and ammonia levels. [Client C] has also recently completed a sleep study. We do not currently have lab results or sleep study results...Recommendations: 1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>PC/PD will schedule an appt (appointment) with [PCP] to address: recommendations regarding Provigil (medication to increase alertness); recommendations regarding need for Keppra (seizures); discuss results and get copies from sleep study; request order for wheelchair PRN; discuss order for use of gait belt at all times except when [client C] is seated in his wheelchair and in bed; request order for OT (occupational therapy)/PT (physical therapy) evaluation; request an order for new ted hose (support stockings). 2) PC/PD will begin a 24 hr (hour) sleep chart so [client C's] sleeping can be tracked at the day service and the group home. 3) PC/PD will contact the lab facility to request copies of [client C's] recent labs-results will be scanned to therap (electronic/digital recording system). 4) [Client C's] level of agitation and threats of physical harm to others has decreased since he has had increased medical issues-it is recommended by the staff nurse [name], that staff refrain from using the Zyprexa Zydis PRN medication as [client C] is not currently a physical harm to others. If staff question [client C's] agitation and feel he is a threat to himself or others, the PC/PD should be contacted...."</p> <p>Client C's MAR (medication</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/09/2015
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012		
(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>administration record) dated 10/2015 failed to indicate a sleep chart for client C, the use of a wheelchair or of a rolling walker. The MAR indicated client C's gait belt may be used prn (as needed). The MAR indicated the use of clonazepam .5 mg twice daily and listed the side effect of drowsiness, depakote ER (extended release) 2,000 mg, with a side effect of drowsiness, Keppra (seizures) 500 mg twice daily with a side effect of drowsiness, weakness and dizziness, perphenazine (psychosis) 6 mg with side effects of dizziness, drowsiness and anxiety, Seroquel (anti-psychosis) 400 mg daily with a side effect of drowsiness, and warfarin 6 mg daily and Zyprexa Zydis 5 mg (anti-psychotic) every 8 hours as needed.</p> <p>A General Event Report (GER) in client C's record dated 5/18/15 indicated in the section Event Information "Describe what happened before the event: don't know, client says it happened this morning when another peer was helping him up from the floor...Comments: client says he couldn't get up off the floor, asked him if he fell out of bed, he said trying to get out of bed and slid to floor. Told me staff was aware...." The sections for Corrective Action Taken, Plan of Future Corrective Actions and Follow-Up actions, were blank. The report indicated</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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 residential manager (PC) was notified by staff #2 on 5/18/15 at 8:31 PM. The PD (Program Director)/QIDP (Qualified Intellectual Disabilities Professional) reviewed the report on 5/19/15 at 9:50 AM. There was no evidence the incident was reported to the Area Director or the group home nurse was notified of the incident. There was no evidence in the report of an assessment to determine if client C was injured during the incident. There was no evidence the incident was investigated or additional corrective action had been implemented.</p> <p>A GER dated 6/2/15 indicated client C "was sick last night, staff monitored all night. [Client C] got up this morning and was not feeling well still, had high temp (temperature) (not specified) and low O2 (oxygen level in the blood stream). He was taken to doctor and sent to the emergency room...Comments: [client C] was admitted into the emergency room because of his condition, as of 3 pm he was being admitted into the ICU (intensive care unit)." There was no corrective action or follow up listed in the report. A BDDS report attached to the GER indicated on 6/2/15 at 11:30 AM, client C was taken to the hospital after being sick all night with a high temperature and low O2 saturations. Corrective action indicated "I told the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>staff to do the same thing if he complains about it a lot, then take him to the hospital. So we would use the same plan as before." There was no evidence of additional corrective action indicated in the report.</p> <p>T-Log nursing notes were reviewed on 10/28/15 at 9:50 AM and indicated on 10/6/15, "Called and spoke with [PD] on Sunday regarding [client C], stated hospital states did not have a heart attack, give tylenol as needed. Checked up on [client C] on Monday (date not specified), he appeared tired from increase in psych (psychotropic) meds (medications) but was alert and able to carry on conversatin (sic), c/o (complains of) knees hurting, no other distress noted." The note failed to indicate any follow up action to address client C's chest pain, appearance of being tired or of his knee pain.</p> <p>A note from the nurse dated 10/7/15 indicated PD "notified order received last night to decrease seroquel to 400 mg (milligrams) daily due to lethargy. Called [primary care physician's] office and requested new script for calcium citrate and fax order for seroquel decrease. Client more alert today...."</p> <p>A nursing note dated 10/9/15 indicated</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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 refused body assessment, states, 'I'm OK,' called [primary care physician's] office 2nd time and asked about new script for calcium citrate, awaiting orders."</p> <p>A nursing note dated 10/12/15 indicated client C "continues to deny any injuries from fall, denies any further pain in his chest, c/o right knee pain, no swelling noted, left thumb healing, nail healing and coming off, no s/sx (symptoms) of infection, area pink, no swelling noted."</p> <p>A nursing note dated 10/26/15 at 12:38 PM indicated a social worker at the hospital wanted to talk to her about PT (physical therapy) for client C. The note indicated he would be referred to a home health agency to evaluate and treat client C's needs. The social worker "further advised he will be discharged today-I requested records from his stay be sent with staff upon discharge so we may have in his chart and she advised she would ensure a packet would be made and sent. She could not advise as to any changes in medication. PD/AD/PC advised of above and requested to schedule follow up with [PCP] immediately."</p> <p>A note dated 10/27/15 at 9:15 AM indicated "Upon review of discharge orders it is noted that perphenazine and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>warafin (sic) orders are changed as well. I phoned [Hospital] and spoke with [name] who was working on floor [client C] was on...." The discussion with the nurse at the hospital indicated client C's warfarin (blood thinner) and perphenazine were to be continued as they were upon admission at 6 mg daily warfarin and 6 mg TID of perphenazine. The note indicated client C was to be scheduled for PT evaluation within 48 hours and the PC was aware. The note indicated client C was to see his PCP on 11/2/15.</p> <p>A nursing note dated 10/27/15 indicated client C was assessed and when awakened, indicated he was OK. Client C's vital signs were normal and the nurse noted client C was "somewhat lethargic during assessment but could have just been tired."</p> <p>Additional T-Log nursing notes were reviewed on 10/28/15 at 3:50 PM. A nursing note dated 10/28/15 at 2:51 PM indicated client C was sleeping, but awakened easily. "He was independent in undressing and transferring to his w/c wheelchair...Staff commented that [client C] was more alert and mobile than he has been recently...."</p> <p>A note dated 10/28/15 at 3:08 PM indicated client C was being referred for</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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 CPAP (continuous pressure airway machine) and client C's PCP had sent orders for PT evaluation and treatment and had requested an order for a wheelchair and gait belt for "safety purposes."</p> <p>A nursing note dated 10/28/15 at 3:12 PM indicated the nurse had checked on another client and while at the group home, checked on client C, "I was surprised to see him up and alert and oriented a totally different person that I had assessed 4 hours earlier...."</p> <p>A Polysomnography Report (evaluation of sleep quality) was reviewed on 10/27/15 at 11:45 AM and indicated client C had been diagnosed with "severe obstructive sleep apnea with significant oxygen desaturations," with a total of 305 respiratory events and a calculated apnea (stopping and starting sleep)/hypoxia (lack of oxygen) was 50 events per hour. Client C had an oxygen saturation below 89% for a total of 150 minutes. The report indicated a recommendation to use a CPAP machine to aid in preventing airway obstruction during sleep.</p> <p>A Mayo Clinic website mayoclinic.org reviewed on 10/29/15 at 2:30 PM indicated sleep apnea is a "potentially serious sleep disorder in which breathing</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>repeatedly stops and starts." A side effect listed on the website indicated tiredness even after a full night's sleep.</p> <p>Indiana Mentor Meeting Notes dated 10/19/15 indicated "Discussed falls with [client C] and how to get him up in the morning." There was no additional evidence of specific information in regards to how staff were to assist client C to get up in the morning. Staff present at the meeting included the PC, staff #6, staff #3, staff #4 and day services coordinator #1. There was no evidence staff #2, #5, #7, #8 or #9 as listed on the staff list provided at the entrance of the survey were present or had been provided information from the meeting.</p> <p>The group home nurse was interviewed on 10/27/15 at 11:30 AM and indicated she had just transferred to the group home on 10/26/15 and the Area Director (AD) should be able to provide evidence of staff training for client C's updated risk plan.</p> <p>The AD and Regional Director were interviewed on 10/28/15 at 3:40 PM and indicated client C's risk plan should be specific as to how staff were to use the gait belt, when to use the wheelchair and walker and how to assist client C if he were to fall.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>An electronic/digital message sent to all staff working in the group home dated 10/27/15 at 2:21 PM was reviewed on 10/28/15 at 3:53 PM and indicated client C "is to remain in his wheelchair at all times per hospital orders until further notice." There was no evidence of a physician's order for the use of client C's wheelchair or of staff training to use the wheelchair, transferring client C, assisting him in using the gait belt or what to do if client C fell.</p> <p>The AD was interviewed on 10/28/15 at 3:53 PM and indicated there was no evidence staff had not been trained on client C's plan updated on 10/27/15.</p> <p>The PD was interviewed on 10/28/15 at 4:00 PM and stated, "I didn't elaborate with the notes," and indicated he had instructed staff to use the wheelchair or call the on-call supervisor if client C fell. He indicated he had demonstrated how client C was to be lifted under his arms and how to use the wheelchair. The PD stated, "Sometimes his legs don't work," and stated "We would use a sling (gait belt)" and had demonstrated its use at the meeting. The PD indicated staff #7 and #8 had not attended the meeting and there was no additional training since client C's fall on 10/23/15.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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 AD was interviewed on 11/2/15 at 5:20 PM and indicated the nurse, PD and the PC should have noticed a pattern of client C's falls and addressed them.</p> <p>2. A BDDS report dated 5/23/15 and reported 5/28/15 indicated "staff stated that he was driving the Vehicle to drop off another client at workshop. He turned a corner and rear passenger side strap failed and released tension causing the chair to fall over. Client B was unharmed but needed to be picked up by three individuals because the wheelchair was heavy." Corrective action indicated "Retrain Staff on reporting incident, bus safety, as well as contact PC or PD as soon as accident happens.</p> <p>An investigation dated 6/1/15 completed by the PD was reviewed on 10/27/15 at 11:00 AM and indicated the following interviews with clients A, E, F and B and by staff #15:</p> <p>Client E indicated in an interview on 6/2/15 he saw client B fall over on his side and "he had to yell at [staff #15] twice to stop the bus because [client B] was over on his side...stated that he said something to him (unspecified) about the straps being put on correctly (sic) he also stated that [staff #15], [client F] and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>himself had to lift [client B] off the ground. Stated that the music was up a little loud and that's why he had to yell twice at [staff #15] to get his attention to stop the bus."</p> <p>Client B indicated in an interview on 6/2/15 "stated that he felt like [staff #15] was driving fast on that day. Stated that he felt his straps was (sic) not put on correctly and said that [client E] said something to [staff #15] about the straps not being on right. [Client B] stated that he (unspecified) had the radio loud and couldn't hear him. [Client B] stated that he was telling [staff #15] he was falling over and presumed to turn up the radio. Stated that once he fell over [client E] yelled at [staff #15] to stop the bus. [Client B] stated that [client E] tried to pick him up but was too heavy and by that time [client F] and [staff #15] was (sic) helping lift him."</p> <p>Client A indicated in an interview on 6/2/15 "they had to call [staff #15] a few times to get his attention," and indicated staff #15, and clients E and F assisted client B up off the ground and secured the straps.</p> <p>Client F indicated in an interview on 6/2/15 client E had to call staff #15 twice to get his attention after client B fell over</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>before staff #15 stopped to get client B up and secure the tie downs to his wheelchair before driving client A to work.</p> <p>Staff #15 indicated in an interview on 6/3/15 "that [client F] and a few others yelled at him and he said once he looked back and seen (sic) [client B] was on the ground he had to pull over. Stated the rear right hand side belt failed and released...." When staff #15 was asked why he didn't report it, "Stated he didn't report it because it just slipped his mind because he had a lot going on that weekend with his fiance being in the hospital...."</p> <p>The conclusion of the investigation indicated "Evidence supports staff did not follow protocol(s). Recommendations/Corrective Measures to Prevent the Likelihood of Future Occurrences: Staff will be retrained on and sign off on call procedures and attendance policy. Staff will be retrained on tie-downs. Staff will monitor an injury's (sic) for [client B] and report concerns immediately."</p> <p>The Area Director (AD) was interviewed on 10/27/15 at 11:35 AM and indicated staff #15 should have received corrective action of re-training on tie downs as</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>indicated in the investigation. She indicated the investigation should have addressed the client's statements about staff #15 driving fast and having the music on so loud he could not hear them yelling when client B fell over in his wheelchair.</p> <p>Staff #15's Behind the Wheel Company Vehicle Driving Training Checklist dated 8/4/14 was reviewed on 11/4/15 at 1:45 PM and indicated staff #15 had been trained on safe driving, including "maintains a safe following distance and speed limits," and "did lift w/(with) empty w/c (wheelchair). Still needs tie down training."</p> <p>The AD indicated on 11/5/15 at 11:59 AM, there was no evidence staff #15 had been retrained on vehicle tie-downs or van safety at the group home.</p> <p>3. A BDDS report dated 6/6/15 at 10:23 PM indicated "[Client A] and [Client I] were on an outing with [staff #15] and upon arriving back home the other staff working [staff #6] seen (sic) that something was wrong with [staff #15]. It was reported to [staff #6] that [staff #15] took [client A] and [client I] on a location not approved by the PD or PC. It was report (sic) to [staff #6] that [client A] and [client I] may have been left in the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>van up to 30 minutes unintended (sic). It was reported that [staff #15] was suspected to be under the influence of something and was found in the living room asleep on the couch. Upon reciving (sic) these concerns [staff #6] contacted the on call PC and the on call PC informed the PD and the PD went to the home and found [staff #15] sleep (sic). PD suspended [staff #15] immediately and sent him home. PD checked to make sure everyone in the house was safe. PD also was in contact with other home manager for [client I] to inform them of the situation and ensure [client I's] safety. There was (sic) no injuries observed and reported." Corrective action indicated "Staff has been suspended upon completion of (sic) investigation."</p> <p>A Summary of Internal Investigation Report dated 6/10/15 was reviewed on 10/27/15 at 10:40 AM and indicated the following:</p> <p>An undated interview with PC #3 indicated she had received a call from staff #6, reporting that staff #15 was "passed out" in the office. Staff #6 indicated to PC #3 that staff #15 had left "approximately 6 pm with the client [client A], and returned to the home at 9:40 PM. Said [staff #6] told her [staff #15] appeared to be having trouble</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>walking into the home when he returned. Said [client A] had reported to [staff #6] that [staff #15] had taken him and [client I] to his home, got out of the car without saying anything to them and left them in the car for a period of time and when they were coming home [staff #15] was driving 'reckless'...."</p> <p>An undated interview with the PD indicated when he arrived at the group home at 11 PM, "[staff #6] informed him that [staff #15] was still asleep and she was afraid he might come up swinging when he was awakened. Said he observed [staff #15] lying on the couch on his side with a pillow under his head, his shoes off, and a blanket covering him to his neck. Said he tapped [staff #15] several times and asked him to wake up. Said when [staff #15] did not wake up he shook [staff #15's] leg and spoke louder. Said [staff #15] then open (sic) one eye and looked at him. Said he directed [staff #15] to get up and leave. Said [staff #15] got up from the couch without saying anything and stood looking at him for several minutes before he again informed [staff #15] he needed to get his shoes on and leave. Said [staff #15] then got his shoes and left slamming the door without saying a word....Said when he interviewed [client A], [client A] looked concerned. [Client A] told him [staff</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>#15's] driving scared him. [Client A] said [staff #15] hit a median and almost hit another car demonstrating with his hands. [Client A] said [staff #15] was acting different on their way home...Said [client A] and [client I] require supervision during their dates to reduce opportunities for inappropriate sexual behavior between them. Said [client A] told him he and [client I] kissed while they were waiting for [staff #15] to come out of the house...Said he did receive a text on 6/7/15 from [staff #15]."</p> <p>An undated interview with client A indicated he and client I were taken to a restaurant for about 30 minutes and then went to the house where they have never been before. "Said [staff #15] left them in the car for 30 minutes while he was in the house. Said on the way home he was scared because [staff #15] hit a median and almost hit another car...."</p> <p>An undated interview with client E indicated staff #15 "sleeps whenever he works by himself."</p> <p>An undated interview with staff #15 indicated he "fell asleep on 6/6/15 because the medication he has been prescribed makes him drowsy." Staff #15 denied taking client A and client I anywhere other than driving around so</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>that they could spend time together."</p> <p>The conclusion of the investigation indicated staff #15 admitted he was sleeping on 6/6/15 and was under the influence of medication when transporting clients. Recommendations indicated "HR (human resources) and Operations (administrative staff) to review findings of investigation to determine appropriate corrective action."</p> <p>Client A's record was reviewed on 10/27/15 at 1:05 PM. An ISP (Individual Support Plan) last updated 5/8/14 indicated client A "has to have staff with him on all community outings." The Individual Services Safeguard last updated 2/18/11 indicated for supervision in the community client A required "within visual range (consumer is within eyesight of staff at all times)."</p> <p>The Area Director (AD) was interviewed on 10/27/15 at 11:35 AM and indicated staff #15 had been terminated after the incident on 6/6/15 involving client A. She indicated staff #15's erratic driving under the influence of medication and failure to supervise him had placed client A at risk. She indicated the facility's policy and procedures did not permit staff #15 to be screened for substances he may have been under the influence of at the time of the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>incident involving client A. She indicated there was no evidence in the investigation client I had been interviewed. The AD indicated corrective action to ensure clients were not at risk included ongoing monitoring by the group home PC (Program Coordinator) on a daily basis and by the PD (Program Director) on a weekly basis. She indicated she would look for evidence of monitoring by the PC and PD.</p> <p>The AD was interviewed on 11/2/15 at 5:10 PM and when asked about evidence of PC monitoring visits, indicated she would look for documentation, and stated, there were "not too many." There was no evidence of monitoring/observations by the PC provided prior to 10/28/15.</p> <p>Documentation of the PD's monitoring of the group home was reviewed on 10/27/15 at 10:35 AM and indicated he had visited the home on 6/11/15 from 4:00 PM until 5:30 PM, on 7/16/15 from 12:00 PM-1:00 PM, on 9/12/15 from 10:00 AM until 11:30 AM, on 9/29/15 at 9:30 AM and again on 10/15 from 1:00 PM until 3:30 PM. There was no evidence of visits on a weekly basis.</p> <p>Client A was interviewed on 10/29/15 at 7:55 PM. When asked about the incident</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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
W 0159 Bldg. 00	<p>in which staff #15 had left him and client I alone on the van, he stated it was his birthday that day and he and client I had gone out to eat. Staff #15 then drove them to an unknown location/home and staff #15 left him and client I alone "for awhile." Client A indicated when staff #15 drove him and client I home, he was weaving (as demonstrated by moving his hands) on the road. Client indicated he was scared when staff #15 drove him home that evening.</p> <p>This federal tag relates to complaints #IN00175282 and #IN00185516.</p> <p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>Based upon record review and interview for 3 of 4 sampled clients (clients A, B and C), the QIDP (Qualified Intellectual Disabilities Professional) failed to document falls and report them to the administrator and to BDDS (Bureau of Developmental Disabilities Services) and to investigate falls resulting in injury, hospital visits and requiring the use of emergency medical personnel to assist client C after falling. The QIDP failed to develop and implement effective corrective action to protect client C from falls after a history of falls was identified. The QIDP failed to ensure staff were trained to competency to protect client B from his wheelchair falling over during transport as a result of improper securing of his wheelchair. The QIDP failed to develop and implement effective corrective action to address staff's unsafe driving habits after they had been identified in an investigation. The QIDP failed to thoroughly investigate an incident involving client A being left alone and staff's unsafe driving.</p> <p>Findings include:</p> <p>1. The QIDP failed to develop and implement effective corrective action to</p>	W 0159	<p>W 159 QIDP</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · Training completed with the staff regarding: <ul style="list-style-type: none"> o Abuse, neglect and exploitation-what constitutes abuse, report expectations and investigation expectations (competency test provided) o When to contact the Program Coordinator o How to properly secure a wheelchair in the bus using the wheelchair tie downs for Client B o Training regarding the risk plans and health needs for Clients B, C and D. o Review the supervision needs for Client A o Behavior plans and/or documentation expectations for Clients A-H o Staff approach o Vehicle use and safe driving training · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will be retrained on the appointment process 	12/09/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>protect client C from falls after a history of falls was identified. The QIDP failed to ensure staff were trained to competency to protect client B from his wheelchair falling over during transport as a result of improper securing of his wheelchair. The QIDP failed to ensure staff implemented identified supervision needs for client A and failed to develop and implement effective corrective action to address staff's unsafe driving habits after they had been identified in an investigation. The QIDP failed to thoroughly investigate an incident involving client A being left alone and staff's unsafe driving. Please see W149.</p> <p>2. The QIDP failed for 2 of 4 sampled clients (clients B and C), to document falls and report them to the administrator and to BDDS (Bureau of Developmental Disabilities Services) in accordance to state law. Please see W153.</p> <p>3. The QIDP failed for clients A, B and C, to thoroughly investigate falls involving clients B and C. The QIDP failed to thoroughly investigate an incident involving client A being left alone and staff's unsafe driving. Please see W154.</p> <p>4. The QIDP failed to develop and implement effective corrective action to</p>		<p>expectations, following physician recommendations and communication expectations with the nurse.</p> <ul style="list-style-type: none"> · The Program Director will be trained on reportable incidents and notifying the administrator. · The Program Director will be retrained on implementing corrective actions to address staff performance concerns and regarding recommendations made from investigations. · The Program Director will be retrained on investigation expectations and completing thorough investigations. · The Program Director will be retrained on the role and expectations of the QIDP. · The Program Director will be retrained on the IDT process. · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. These staffings are led by the QIDP. · The IDT will monitor trends and patterns in client reportable incidents. The IDT will convene as necessary to discuss an increase in reportable incidents such as falls. · Staff #4 has been retrained by the Behavior Clinician on Client F's behavior plan. <p>2. How will we identify other</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>protect client C from falls after a history of falls was identified. The QIDP failed to protect client B from his wheelchair falling over during transport as a result of improper securing of his wheelchair, and failed to provide supervision and protect client A from impaired/unsafe driving by the same staff who failed to secure the wheelchair properly. The QIDP failed to implement effective corrective action to address the staff's unsafe driving habits after they had been identified in an investigation. Please see W157.</p> <p>5. The QIDP failed to train staff competently on the behavioral needs of 1 additional client (client F). Please see W191.</p> <p>6. The QIDP failed to train staff competently on the health needs of 1 of 4 sampled clients (client C). Please see W192.</p> <p>This federal tag relates to complaints #IN00175282 and #IN00185516.</p> <p>9-3-3(a)</p>		<p>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 do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: <ul style="list-style-type: none"> o Abuse, neglect and exploitation-what constitutes abuse, report expectations and investigation expectations (competency test provided) o When to contact the Program Coordinator o How to properly secure a wheelchair in the bus using the wheelchair tie downs for Client B o Training regarding the risk plans and health needs for Clients B, C and D. o Review the supervision needs for Client A o Behavior plans and/or documentation expectations for Clients A-H o Staff approach o Vehicle use and safe driving training · The Program Director will be retrained on the appointment process expectations, following physician recommendations and communication expectations with the nurse. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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
			<ul style="list-style-type: none"> · The Program Director will be trained on reportable incidents and notifying the administrator. · The Program Director will be retrained on implementing corrective actions to address staff performance concerns and regarding recommendations made from investigations. · The Program Director will be retrained on investigation expectations and completing thorough investigations. · The Program Director will be retrained on the role and expectations of the QIDP. · The Program Director will be retrained on the IDT process. · The Program Director will be retrained on the expectations for the medical charts. · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · Competency training with the nurse was completed with staff on 10-28 and 10-29-15 which included one person transfers, two person transfers, use of a gait belt, wheelchair safety, and one person assist. · Training was completed by the nurse on 10-29-15 included body mechanics/safe transfers, updated fall risk plan for Client C, adaptive equipment and change in health 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>status reporting.</p> <ul style="list-style-type: none"> · The IDT will monitor trends and patterns in client reportable incidents. The IDT will convene as necessary to discuss an increase in reportable incidents such as falls. <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 do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: <ul style="list-style-type: none"> o Abuse, neglect and exploitation-what constitutes abuse, report expectations and investigation expectations (competency test provided) o When to contact the Program Coordinator o How to properly secure a wheelchair in the bus using the wheelchair tie downs for Client B o Training regarding the risk plans and health needs for Clients B, C and D. o Review the supervision needs for Client A o Behavior plans and/or documentation expectations for Clients A-H o Staff approach o Vehicle use and safe driving training · The Program Director will be 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>retrained on the appointment process expectations, following physician recommendations and communication expectations with the nurse.</p> <ul style="list-style-type: none"> · The Program Director will be trained on reportable incidents and notifying the administrator. · The Program Director will be retrained on implementing corrective actions to address staff performance concerns and regarding recommendations made from investigations. · The Program Director will be retrained on investigation expectations and completing thorough investigations. · The Program Director will be retrained on the role and expectations of the QIDP. · The Program Director will be retrained on the IDT process. · The Program Director will be retrained on the expectations for the medical charts. · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · Competency training with the nurse was completed with staff on 10-28 and 10-29-15 which included one person transfers, two person transfers, use of a gait belt, wheelchair safety, and one person assist. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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
			<ul style="list-style-type: none"> · Training was completed by the nurse on 10-29-15 included body mechanics/safe transfers, updated fall risk plan for Client C, adaptive equipment and change in health status reporting. · The IDT will monitor trends and patterns in client reportable incidents. The IDT will convene as necessary to discuss an increase in reportable incidents such as falls. <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 to ensure the clients plans and needs are being met during their bi-weekly observations. · New staff hired to work at the site will receive client specific training for each individual prior to working a shift. This training includes items such as: client's diets, risk plans, ISP's, programming, and medication review. · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · Monthly supervisory visit check sheets to be completed by the QIDP. These will be forwarded to the Area Director for review. · The QIDP will monitor and review the resident's needs. As the needs arise, formal programming will 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>be implemented.</p> <ul style="list-style-type: none"> · Quarterly Health and Safety assessments will be completed by the Program Coordinator and/or the Program Director and forwarded to the Quality Improvement department. These assessments include a review of the environmental needs for the home, review of risk plans, ISP, BSP and client specific training for the residents. The assessment also includes an interview of staff to ensure they know how to properly document medical needs, how to report incidents, diets and understanding of BSP's. · The Quality Improvement Department and the Area Director will monitor incidents as they are reported to ensure that they are reported timely and that all required incidents are reported to BDDS. · New staff hired to work at the site will receive training on reportable incidents, reporting expectations and who to contact. · All abuse and neglect investigations will be reviewed by the Quality Improvement Specialist or her designee to ensure the investigations are thorough. · All investigations that are not considered abuse and neglect will be reviewed by the Area Director or her designee to ensure the investigations are thorough. <p>5. What is the date by which the systemic changes will be</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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
W 0191 Bldg. 00	<p>483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' behavioral needs.</p> <p>Based on observation, record review and interview, the facility failed to train staff competently on the behavioral needs of 1 additional client (client F).</p> <p>Findings include:</p> <p>Observations were completed on 10/27/15 from 7:10 AM until 8:38 AM. At 7:40 AM, client F indicated he was not going to work. Staff #4 stated, "You have to go. You can't stay home," and "Do you want a snack at night? Do you want a brownie?"</p> <p>Client F's records were reviewed on 10/27/15 at 1:16 PM. A Behavior Support Plan (BSP) dated 7/14/15 indicated targeted behaviors of inappropriate social behaviors, noncompliance, inappropriate verbal behavior, physical aggression, property misuse and AWOL (away without leave). Interventions for noncompliance indicated staff should ask client F one time to comply with a necessary request. "If he does not respond, staff should refer</p>	W 0191	<p>completed? December 9th, 2015</p> <p>W 191 Staff Training Program For employees who work with the clients, training must focus on skills and competencies directed toward clients' behavioral needs.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: <ul style="list-style-type: none"> o Behavior plans and/or documentation expectations for Clients A-H o Staff approach <ul style="list-style-type: none"> · Staff #4 was retrained on Client F's behavior plan by the Behavior Clinician on 11-4-15. · The Behavior Clinician will complete monthly observations or more frequent based on the client's behavioral support needs to ensure staff is implementing the behavior 	12/09/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>him to his schedule and remind him that he would like to be more independent...If [client F] does not comply with the request within 2 minutes, staff should give another prompt without emotion. Staff should simply say, '[Client F] you need to ____.' Nothing further should be said. Staff should not lecture, plead, counsel or reprimand [client F] in any way, as this will likely give him the attention he enjoys...."</p> <p>The Area Director was interviewed on 11/2/15 at 5:20 PM and indicated staff should have implemented client F's plan to address his noncompliance and staff should not have used a directive tone or snacks as an intervention.</p> <p>A document dated 11/4/15 was reviewed on 11/5/15 at 12:34 PM and indicated staff #4 was trained on client F's BSP on 11/4/15.</p> <p>9-3-3(a)</p>		<p>plan appropriately and that the plan is still effective.</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> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: <ul style="list-style-type: none"> o Behavior plans and/or documentation expectations for Clients A-H o Staff approach · The Behavior Clinician will complete monthly observations or more frequent based on the client's behavioral support needs to ensure staff is implementing the behavior plan appropriately and that the plan is still effective. · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/09/2015
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012		
(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>adaptive equipment.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: <ul style="list-style-type: none"> o Behavior plans and/or documentation expectations for Clients A-H o Staff approach · The Behavior Clinician will complete monthly observations or more frequent based on the client's behavioral support needs to ensure staff is implementing the behavior plan appropriately and that the plan is still effective. · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. <p>4. How will the corrective action be monitored to ensure the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>deficient practice will not recur?</p> <ul style="list-style-type: none"> · The Program Director will monitor to ensure the clients plans and needs are being met during their bi-weekly observations. · The Program Coordinator will monitor to ensure the clients plans and needs are being met during their weekly observations. · The Behavior Clinician will complete monthly observations or more frequent based on the client's behavioral support needs to ensure staff is implementing the behavior plan appropriately and that the plan is still effective. · New staff hired to work at the site will receive client specific training for each individual prior to working a shift. This training includes items such as: client's diets, risk plans, ISP's, BSP's, programming, and medication review. · The nurse will be available to do observations within the home for medical related issues as the client's needs indicate. · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · Monthly supervisory visit check sheets to be completed by the QIDP. These will be forwarded to the Area Director for review. · Quarterly Health and Safety 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 11/09/2015
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012		
(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	
W 0192 Bldg. 00	<p>483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>Based on observation, record review and interview, the facility failed to ensure staff were trained to competency on reporting and documenting the health needs of 3 of 4 sampled clients (clients B, C and D).</p> <p>Findings include:</p> <p>Observations were completed at the group home on 10/26/15 from 5:55 PM until 7:06 PM. Client C sat on his bed</p>	W 0192	<p>assessments will be completed by the Program Coordinator and/or the Program Director and forwarded to the Quality Improvement department. These assessments include a review of the environmental needs for the home, review of risk plans, ISP, BSP and client specific training for the residents. The assessment also includes an interview of staff to ensure they know how to properly document medical needs, how to report incidents, diets and understanding of BSP's.</p> <p>5. What is the date by which the systemic changes will be completed? December 9th, 2015</p> <p>W 192 Staff Training Program For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to 	12/09/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>and asked staff #7 to assist him in removing his hospital bracelets, with the exception of the bracelet labeled "fall risk," which he wanted to remain attached to his wrist.</p> <p>The Program Coordinator (PC) was interviewed on 10/26/15 at 6:00 PM and stated client C had returned from the hospital "a couple of hours ago." He indicated client C had fallen on 10/23/15 and may have had the flu.</p> <p>Staff #10 was interviewed on 10/26/15 at 5:55 PM and indicated client C had a history of falls and staff used a gait belt to assist him.</p> <p>Client E was interviewed on 10/26/15 at 6:30 PM and stated client C had been "pushed" by staff #8 causing his fall on 10/23/15.</p> <p>Client C was interviewed on 10/26/15 at 6:31 PM. He stated staff #8 had "pushed me as in rushed. I fell flat on my face." When asked how staff #8 rushed him, client C stated, "Hurry up, we're going to be late. We were outside and I was about to get on the bus."</p> <p>Staff #4 was interviewed on 10/26/15 at 6:50 PM and stated client C "is hard to supervise. He has fallen recently. The</p>		<p>ensure staff are implementing the plans of clients and the client's needs are being met.</p> <ul style="list-style-type: none"> · Training completed with the staff regarding: <ul style="list-style-type: none"> o How to measure wounds o How to document skin/wound findings o How to document falls o When to contact the Program Coordinator o How to properly secure a wheelchair in the bus using the wheelchair tie downs for Client B o Training regarding the risk plans and health needs for Clients B, C and D. o How to monitor and document intake and elimination o How to properly cath Client D o Review the supervision needs for Client A o Staff duty sheets and cleaning expectations o Vehicle use and safe driving training <ul style="list-style-type: none"> · Competency training with the nurse was completed with staff on 10-28 and 10-29-15 which included one person transfers, two person transfers, use of a gait belt, wheelchair safety, and one person assist. · Training was completed by the nurse on 10-29-15 included body mechanics/safe transfers, updated fall risk plan for Client C, adaptive equipment and change in health status reporting. · The nurse will conduct quarterly staff observations to ensure 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>meds he's on make him drowsy-when he falls it's hard to catch him." Staff #4 indicated client C had a fall risk plan to use a gait belt and a walker. Staff #4 indicated if client C falls, staff were to call the HM (house manager)/PC and indicated emergency medical services staff had to assist with client C to get up after falls twice on 10/23/15. Staff #4 indicated she not been present when client C had fallen and had been able to stop him from falling by asking him to stand up straight.</p> <p>Observations were completed again at the group home on 10/27/15 from 7:10 AM until 8:38 AM. Staff #8 assisted client C to get up from his bed using a gait belt. Client C used a rolling walker to go to the kitchen and sat on a wooden kitchen chair. Staff #8 and #9 assisted client C to get up from the chair using a gait belt and to use his walker. Staff #9 showed staff #8 how to position the gait belt for client C and how to position client C to his walker to aid him in rising from the chair. Client C requested a wooden chair to sit on in the living room and sat on the chair without arms with his head slumped toward his chest and his eyes closed. Client C's color was pale and of a yellow tint, and he aroused and indicated he was tired. Staff #9 assisted client C using a gait belt and asked him to count to 3 and</p>		<p>continued competency over adaptive equipment, body mechanics/safe transfers.</p> <ul style="list-style-type: none"> · Client Specific training for new staff will include body mechanics/safe transfers and the use of a gait belt. <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 Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: <ul style="list-style-type: none"> o How to measure wounds o How to document skin/wound findings o How to document falls o When to contact the Program Coordinator o How to properly secure a wheelchair in the bus using the wheelchair tie downs for Client B o Training regarding the risk plans and health needs for Clients B, C and D. o How to monitor and document 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>stand using his walker. Client C stood up and used his walker to walk to his room. Staff #9 instructed client C to keep his walker close to him while he walked for stability and to assist him in standing straighter and complimented him on his ability to stand.</p> <p>Staff #8 and #9 were interviewed on 10/27/15 at 7:25 AM. Staff #9 indicated she was a CNA (certified nursing assistant).</p> <p>Staff #8 indicated he had not been trained on specific client interventions for client C, and client C had been found on the floor of his bedroom at 3:00 AM on 10/23/15 when he was working with staff #7 on the overnight shift. He indicated client C normally got up at 4:00 AM for his shower to give him extra time. He indicated he and staff #7 had attempted to get client C up using the gait belt, but weren't able to get him up. Staff #8 indicated he had called 911 and on-call staff, and due to the emergency (with client C on the floor) the fire department had arrived to assist client C to get up. Staff #8 stated, client C "went on with his day and showered. My shift was over and I was off the clock. I was walking him out and I don't know if he missed his step (on the driveway) or missed his footing, and I tried to stop it (fall). He's a pretty</p>		<p>intake and elimination</p> <ul style="list-style-type: none"> o How to properly cath Client D o Review the supervision needs for Client A o Vehicle use and safe driving training <ul style="list-style-type: none"> · Competency training with the nurse was completed with staff on 10-28 and 10-29-15 which included one person transfers, two person transfers, use of a gait belt, wheelchair safety, and one person assist. · Training was completed by the nurse on 10-29-15 included body mechanics/safe transfers, updated fall risk plan for Client C, adaptive equipment and change in health status reporting. · The nurse will conduct quarterly staff observations to ensure continued competency over adaptive equipment, body mechanics/safe transfers. · Client Specific training for new staff will include body mechanics/safe transfers and the use of a gait belt. <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 Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>good sized guy-my size and just the momentum...we called 911 and then the HM (house manager)/PC. I told the HM I could leave, staff were here with him. I don't know what happened as I left. I normally clock out at 8:00 AM, it was after that."</p> <p>Staff #7 was interviewed on 10/27/15 at 8:20 AM. Staff #7 stated client C was currently asleep in his room, client C was better 2-3 weeks ago and has been "like this for a week." Staff #7 indicated client C had been experiencing medication adjustments. Staff #7 indicated she had been present when client C fell on 10/23/15 on the overnight shift and at 9:00 AM. She saw client C fall as she went around the back of the van to assist with the lift. She stated staff #8 "was right in front of him. He was walking to his car to leave and was not assisting [client C]." Staff #7 indicated client C took about 30 minutes to leave the kitchen to get to the van on the morning of 10/23/15 prior to his fall and was not rushed. She indicated she had not received client specific training for client C to assist him using the gait belt or address his falls.</p> <p>Client C's discharge orders from the hospital were reviewed on 10/26/15 at 6:28 PM. The discharge orders indicated</p>		<p>ensure staff are implementing the plans of clients and the client's needs are being met.</p> <ul style="list-style-type: none"> · Training completed with the staff regarding: <ul style="list-style-type: none"> o How to measure wounds o How to document skin/wound findings o How to document falls o When to contact the Program Coordinator o How to properly secure a wheelchair in the bus using the wheelchair tie downs for Client B o Training regarding the risk plans and health needs for Clients B, C and D. o How to monitor and document intake and elimination o How to properly cath Client D o Review the supervision needs for Client A o Vehicle use and safe driving training <ul style="list-style-type: none"> · Competency training with the nurse was completed with staff on 10-28 and 10-29-15 which included one person transfers, two person transfers, use of a gait belt, wheelchair safety, and one person assist. · Training was completed by the nurse on 10-29-15 included body mechanics/safe transfers, updated fall risk plan for Client C, adaptive equipment and change in health status reporting. · The nurse will conduct quarterly staff observations to ensure continued competency over adaptive equipment, body mechanics/safe 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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 C's clonazepam was reduced to 5 mg (milligrams) from 10 mg. There was no other information in regards to client C's diagnosis or instructions to address client C's follow up care.</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services were reviewed on 10/27/15 at 10:15 AM and included the following for client C:</p> <p>A BDDS report dated 5/8/15 indicated on 5/8/15 at 6:25 AM, client C fell during his shower. Staff reported client C bruised his bottom (size and specific location not indicated). Client C later stated, "that he may have hit his head when falling. PC (Program Coordinator) contacted the nurse consultant and was advised to take [client C] to the ER (emergency room). Corrective action indicated the PC would follow recommendations of (sic) nurse consultant and ER physician. Staff will continue to monitor for any changes and report concerns immediately."</p> <p>A BDDS report dated 10/3/15 indicated client C "was having chest pains and thought he was having a heart attack so staff called the ambulance were (sic) he was taken to the hospital and treated. Hospital stated he was having an (sic) just pains and gave him tylenol. Hospital</p>		<p>transfers.</p> <ul style="list-style-type: none"> · Client Specific training for new staff will include body mechanics/safe transfers and the use of a gait belt. <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 to ensure the clients plans and needs are being met during their bi-weekly observations. · The Program Coordinator will monitor to ensure the clients plans and needs are being met during their weekly observations. · Mentor's nurse will be in the home on a weekly basis or more frequently as needed to monitor for concerns and assess residents. · New staff hired to work at the site will receive client specific training for each individual prior to working a shift. This training includes items such as: client's diets, risk plans, ISP's, programming, and medication review. · The nurse will be available to do observations within the home for medical related issues as the client's needs indicate. · Quarterly Health and Safety assessments will be completed by the Program Coordinator and/or the Program Director and forwarded to the Quality Improvement department. These assessments include a review of the environmental needs for the home, review of risk plans, ISP, BSP and client specific training for the 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/09/2015
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012		
(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>staff stated if chest pain continues after 3 to 4 days then go see his doctor." Corrective action indicated "Staff will continue to follow mentor (sic) policy as stated."</p> <p>A BDDS report dated 10/7/15 indicated on 10/7/15 at 7:10 PM, client C was found by the staff on the bedroom floor, "staff tried to help [client C] up, other client (unspecified) called ambulance, ambulance came and helped [client C] up, there appears to be no injury, but staff will continue to check throughout the shift." Corrective action indicated "Follow Mentors (sic) policy and Procedure on Falls."</p> <p>A BDDS report written by the PD dated 10/23/15 was reviewed on 10/23/15 at 12:20 PM and indicated at 9:00 AM, client C "was walking to the bus lift where his legs gave out and he fell chest first into (sic) the driveway. i (sic) evaluated him, no blood, did not loose (sic) consciousness, complained of pain in both wrist (sic), both legs, and in his face and right eye, called ambulance. [Client C] was taken to the hospital and kept for an overnight observation. Corrective action indicated "Follow Mentors (sic) policy on falls."</p> <p>An investigation into the incident on</p>		<p>residents. The assessment also includes an interview of staff to ensure they know how to properly document medical needs, how to report incidents, diets and understanding of BSP's.</p> <p>5. What is the date by which the systemic changes will be completed? December 9th, 2015</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>10/23/15 dated 10/24/15 was reviewed on 10/27/15 at 12:20 PM and indicated the same information as provided in the BDDS report in regards to the incident. Staff #7, client C and the PC were interviewed as part of the investigation. Staff #7 indicated in her interview she was in the process of taking the clients out to the bus so they could go to day services. The interview indicated staff #7 stated "Everything was fine until [client C] just fell all of a sudden, [client C] told her his legs just give (sic) out and they don't want to work right sometimes, he was complaining about his wrist and legs hurting and that she called the Ambulance, the PC just pulled up." The PC indicated he had just pulled up to the group home and found that client C had just fallen. The PC indicated he went with client C to the hospital and the nurse wanted to keep client C overnight to run tests. Client C was interviewed and stated, "he was walking to the bus and his legs just gave out on him, his legs stops (sic) working from time to time and he was in some pain and wanted to go to the hospital."</p> <p>A Preliminary Report of Alleged Adult Endangerment was reviewed on 10/28/15 at 9:30 AM and indicated " On 10/26/15 APS (Adult Protective Services) received the following report: ...Please see the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>attached police report from [county] regarding [client C] (Victim). Victim (client C) is mentally handicapped. Victim resides in a group home believed to be under the supervision of REM-Indiana Mentor/Occazio ...According to the police report, [client C] is around 5' (feet) 10" (inches) and weighs over 300 lbs (pounds). Officer [name] states in her report that this is the second time in two weeks that she has been to the home due to Victim falling in the driveway. The first occurrence was on 10/15/15. Also Officer [name] was advised that the [township name] Fire Department was out on Victim around 4:00 (AM/PM not specified) on this date, 10/23/15 due to victim falling out of bed. There is concern over a lack of staff or supervision at the group home to assist Victim and also inadequate equipment to accommodate Victim " An attached police report indicated a Case Narrative " On 10/23/15, I assisted with [township] Fire Department on an injured (sic) in a fall at [group home address]. This is a group home. This is the second time in 2 weeks that I have been to the group home in regards to the same client falling in the driveway. The prior incident was 10/15/15. I was advised the fire department was requested around 04:00 on 10/23/15 due to [client C] falling out of bed. I was advised the fire department</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/09/2015
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012		
(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>assisted [client C] in standing.</p> <p>On 10/15/15, [client C] had fell (sic) in the driveway. [Client C] is approximately 5'10" and weighs over 300 pounds. The fire department assisted [client C] in standing and getting him back into a van. The fire department requested a wheelchair due to the distance the van was due to where [client C] fell. A wheelchair was brought out from the facility that would not be large enough for a large adult let alone a client that is obese as [client C]. On this occasion [client C] was unsteady on his feet and was unable to walk without assistance. The fireman had to place each of [client C 's] legs into the van. The (sic) they had to push on his bottom to move him over so that the door would close. [Client C] attempted to assist but trembled as he tried to move his own weight. There was a small bus that was picking up some of the clients. It is my understanding that [client C] would have to climb the stairs in order to get on the small bus. The bus is equipped with a ramp. One of the fireman advised that someone from the group home advised that there has not had (sic) a manager for some time. They also advised that the clients are shipped from this facility to another due to being understaffed during the daytime. The staff was little to no help in getting</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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 C] on the van.</p> <p>On 10/23/15, [client C] was lying face down on the driveway, which is a slight decline. His face was toward the downward slope and facing opposite of the house. [Client C] had a blanket draped over him, but he was shaking. I spoke to [client C] and he complained of pain to his head. There was no blood or obvious injuries that I could see. [Client C] stated the staff tell him it is his fault that he falls because he gets in too big of a hurry. A walker was close to [client C]. One of the fire personnel advised the walker appeared to be too small for the size of [client C].</p> <p>I overheard one of the staff say his medication was changed and there should be improvements.</p> <p>The concern in if the equipment for [client C] is adequate for his size, as well as if there is adequate staff to deal with [client C 's] needs. [Client C] is a mentally disabled individual and may not be able to adequately express his needs or provide for himself to attain what he needs. " There was a note at the bottom of the report "Forward to Adult Protective Services. "</p> <p>Client C's record was reviewed on</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>10/27/15 at 12:55 PM. A visit to client C's primary care physician dated 9/14/15 indicated client C weighed 333.9 pounds in 4/15. There were no other records found to indicate client C's weight. There was no evidence of an updated Individual Support Plan since his last ISP dated 3/4/15.</p> <p>A Risk Plan updated on 10/27/15 and previously updated on 10/14/11 indicated client C's risks included, but were not limited to medication side effects, depression, Intermittent Explosive Disorder, Personality Disorder, Obesity, Phlebitis (blood clots), warfarin (blood thinner/anti-coagulant) therapy, and history of falls. Client C's risk for warfarin therapy indicated "Warfarin can cause very serious (possibly fatal) bleeding." Client C's falls risk indicated he "has a history of falls and at risk for falls. [Client C] is to be using w/c (wheelchair) and gait belt PRN (as needed) for increased unsteady gait. Staff are to ensure environment free from fall hazards (rugs, cords, etc), if fall occurs assessment to be completed and PC/PD to be phoned regarding fall. If (sic) sustains injury that appears severe/life threatening in nature, they are to initiate EMS (emergency medical services) prior to notification of PC/PD. Obtain vitals and document accordingly." The plan</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>failed to indicate how many staff were to assist client C in using the gait belt, transferring or specific information as to when client C was to use the wheelchair and gait belt and how staff were to assist him with the adaptive equipment. The plan failed to indicate the use of client C's rolling walker.</p> <p>IDT (interdisciplinary) meeting notes on 10/16/15 in client C's record entered by the Behavior Analyst (BA) indicated client C "has been observed falling asleep, having difficulty walking, standing, getting out of bed." The note indicated client C's psychiatrist nurse practitioner (NP) had "increased Seroquel (anti-psychotic) from 400 mg (milligrams) daily to 400 mg BID (twice daily), changed Depakote (seizures/mood stability) from 2,000 mg at bedtime to 1,000 mg BID, changed Clonazepam (anxiety) from 1 mg BID to 1 mg TID (three times daily), added Zyprexa Zydys 5 mg PRN (as needed) for agitation on September 16, 2015. After med (medication) change, staff nurse, [name] stated [client C] had increased his falls over the weekend and contacted [client C's] [primary care physician (PCP)] to request a med decrease of Seroquel. [PCP], decreased Seroquel back to 400 mg daily-other psych med changes made by [NP] were continued. Even after</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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
	dosage change of Seroquel, [client C] displays frequent difficulty ambulating requiring the fire department to be contacted three times during the month of October to assist staff in helping [client C] get up/ambulate. [Client C] has also been taken to the ER twice since his admission due to reports he was having a heart attack on one occasion and reports he was having difficulty walking on the second occasion-no medical confirmation was made at either ER visit. [Client C] had some med changes that occurred at the nursing home prior to his admission to the group home on September 11, 2015. Said changes that included Provigil discontinued and Keppra added. [Client C] has completed labs to check Depakote and ammonia levels. [Client C] has also recently completed a sleep study. We do not currently have lab results or sleep study results...Recommendations: 1) PC/PD will schedule an appt (appointment) with [PCP] to address: recommendations regarding Provigil (medication to increase alertness); recommendations regarding need for Keppra (seizures); discuss results and get copies from sleep study; request order for wheelchair PRN; discuss order for use of gait belt at all times except when [client C] is seated in his wheelchair and in bed; request order for OT (occupational therapy)/PT (physical therapy)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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; request an order for new ted hose (support stockings). 2) PC/PD will begin a 24 hr (hour) sleep chart so [client C's] sleeping can be tracked at the day service and the group home. 3) PC/PD will contact the lab facility to request copies of [client C's] recent labs-results will be scanned to therap (electronic/digital recording system). 4) [Client C's] level of agitation and threats of physical harm to others has decreased since he has had increased medical issues-it is recommended by the staff nurse [name], that staff refrain from using the Zyprexa Zydis PRN medication as [client C] is not currently a physical harm to others. If staff question [client C's] agitation and feel he is a threat to himself or others, the PC/PD should be contacted...."</p> <p>Client C's MAR (medication administration record) dated 10/2015 failed to indicate a sleep chart for client C, the the use of a wheelchair or of a rolling walker. The MAR indicated client C's gait belt may be used prn (as needed). The MAR indicated the use of clonazepam .5 mg twice daily and listed the side effect of drowsiness, depakote ER (extended release) 2,000 mg, with a side effect of drowsiness, Keppra (seizures) 500 mg twice daily with a side effect of drowsiness, weakness and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>dizziness, perphenazine (psychosis) 6 mg with side effects of dizziness, drowsiness and anxiety, Seroquel (anti-psychosis) 400 mg daily with a side effect of drowsiness, and warfarin 6 mg daily and Zyprexa Zydys 5 mg (anti-psychotic) every 8 hours as needed.</p> <p>A General Event Report (GER) in client C's record dated 5/18/15 indicated in the section Event Information "Describe what happened before the event: don't know, client says it happened this morning when another peer was helping him up from the floor...Comments: client says he couldn't get up off the floor, asked him if he fell out of bed, he said trying to get out of bed and slid to floor. Told me staff was aware...." The sections for Corrective Action Taken, Plan of Future Corrective Actions and Follow-Up actions, were blank. The report indicated the residential manager (PC) was notified by staff #2 on 5/18/15 at 8:31 PM. The PD (Program Director)/QIDP (Qualified Intellectual Disabilities Professional) reviewed the report on 5/19/15 at 9:50 AM. There was no evidence the incident was reported to the Area Director or the group home nurse was notified of the incident. There was no evidence in the report of an assessment to determine if client C was injured during the incident.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/09/2015	
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012			
(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 GER dated 6/2/15 indicated client C "was sick last night, staff monitored all night. [Client C] got up this morning and was not feeling well still, had high temp (temperature) (not specified) and low O2 (oxygen level in the blood stream). He was taken to doctor and sent to the emergency room...Comments: [client C] was admitted into the emergency room because of his condition, as of 3 pm he was being admitted into the ICU (intensive care unit)." There was no corrective action or follow up listed in the report. A BDDS report attached to the GER indicated on 6/2/15 at 11:30 AM, client C was taken to the hospital after being sick all night with a high temperature and low O2 saturations. Corrective action indicated "I told the staff to do the same thing if he complains about it a lot, then take him to the hospital. So we would use the same plan as before."</p> <p>T-Log nursing notes were reviewed on 10/28/15 at 9:50 AM and indicated on 10/6/15, "Called and spoke with [PD] on Sunday regarding [client C], stated hospital states did not have a heart attack, give tylenol as needed. Checked up on [client C] on Monday (date not specified), he appeared tired from increase in psych (psychotropic) meds (medications) but was alert and able to</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>carry on conversatin (sic), c/o (complains of) knees hurting, no other distress noted." The note failed to indicate any follow up action to address client C's chest pain, appearance of being tired or of his knee pain.</p> <p>A note from the nurse dated 10/7/15 indicated PD "notified order received last night to decrease seroquel to 400 mg (milligrams) daily due to lethargy. Called [primary care physician's] office and requested new script for calcium citrate and fax order for seroquel decrease. Client more alert today...."</p> <p>A nursing note dated 10/9/15 indicated "Client refused body assessment, states, 'I'm OK,' called [primary care physician's] office 2nd time and asked about new script for calcium citrate, awaiting orders."</p> <p>A nursing note dated 10/12/15 indicated client C "continues to deny any injuries from fall, denies any further pain in his chest, c/o right knee pain, no swelling noted, left thumb healing, nail healing and coming off, no s/sx (symptoms) of infection, area pink, no swelling noted."</p> <p>A nursing note dated 10/26/15 at 12:38 PM indicated a social worker at the hospital wanted to talk to her about PT</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>(physical therapy) for client C. The note indicated he would be referred to a home health agency to evaluate and treat client C's needs. The social worker "further advised he will be discharged today-I requested records from his stay be sent with staff upon discharge so we may have in his chart and she advised she would ensure a packet would be made and sent. She could not advise as to any changes in medication. PD/AD/PC advised of above and requested to schedule follow up with [PCP] immediately."</p> <p>A note dated 10/27/15 at 9:15 AM indicated "Upon review of discharge orders it is noted that perphenazine and warafin (sic) orders are changed as well. I phoned [Hospital] and spoke with [name] who was working on floor [client C] was on...." The discussion with the nurse at the hospital indicated client C's warfarin (blood thinner) and perphenazine were to be continued as they were upon admission at 6 mg daily warfarin and 6 mg TID of perphenazine. The note indicated client C was to be scheduled for PT evaluation within 48 hours and the PC was aware. The note indicated client C was to see his PCP on 11/2/15.</p> <p>A nursing note dated 10/27/15 indicated client C was assessed and when awakened, indicated he was OK. Client</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>C's vital signs were normal and the nurse noted client C was "somewhat lethargic during assessment but could have just been tired."</p> <p>Additional T-Log nursing notes were reviewed on 10/28/15 at 3:50 PM. A nursing note dated 10/28/15 at 2:51 PM indicated client C was sleeping, but awakened easily. "He was independent in undressing and transferring to his w/c wheelchair...Staff commented that [client C] was more alert and mobile than he has been recently...."</p> <p>A note dated 10/28/15 at 3:08 PM indicated client C was being referred for a CPAP (continuous pressure airway machine) and client C's PCP had sent orders for PT evaluation and treatment and had requested an order for a wheelchair and gait belt for "safety purposes."</p> <p>A nursing note dated 10/28/15 at 3:12 PM indicated the nurse had checked on another client and while at the group home, checked on client C, "I was surprised to see him up and alert and oriented a totally different person that I had assessed 4 hours earlier...."</p> <p>A Polysomnography Report (evaluation of sleep quality) was reviewed on</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>10/27/15 at 11:45 AM and indicated client C had been diagnosed with "severe obstructive sleep apnea with significant oxygen desaturations," with a total of 305 respiratory events and a calculated apnea (stopping and starting sleep)/hypoxia (lack of oxygen) was 50 events per hour. Client C had an oxygen saturation below 89% for a total of 150 minutes." The report indicated a recommendation to use a CPAP machine to aid in preventing airway obstruction during sleep.</p> <p>A Mayo Clinic website mayoclinic.org reviewed on 10/29/15 at 2:30 PM indicated sleep apnea is a "potentially serious sleep disorder in which breathing repeatedly stops and starts." A side effect listed on the website indicated tiredness even after a full night's sleep.</p> <p>Indiana Mentor Meeting Notes dated 10/19/15 indicated "Discussed falls with [client C] and how to get him up in the morning." There was no additional evidence of specific information in regards to how staff were to assist client C to get up in the morning. Staff present at the meeting included the PC, staff #6, staff #3, staff #4 and day services coordinator #1. There was no evidence staff #2, #5, #7, #8 or #9 as listed on the staff list provided at the entrance of the survey were present at the meeting or had</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>been provided training on how they were to assist client C in getting up or to prevent his falls.</p> <p>The group home nurse was interviewed on 10/27/15 at 11:30 AM and indicated she had just transferred to the group home on 10/26/15 and the Area Director (AD) should be able to provide evidence of staff training for client C's updated risk plan.</p> <p>The AD and Regional Director were interviewed on 10/28/15 at 3:40 PM and indicated client C's risk plan should be specific as to how staff were to use the gait belt, when to use the wheelchair and walker and how to assist client C if he were to fall.</p> <p>An electronic/digital message sent to all staff working in the group home dated 10/27/15 at 2:21 PM was reviewed on 10/28/15 at 3:53 PM and indicated client C "is to remain in his wheelchair at all times per hospital orders until further notice." There was no evidence of a physician's order for the use of client C's wheelchair or of staff training to use the wheelchair, transferring client C, assisting him in using the gait belt or what to do if client C fell.</p> <p>The AD was interviewed on 10/28/15 at</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/09/2015	
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012			
(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>3:53 PM and indicated there was no evidence staff had not been trained on client C's plan updated on 10/27/15.</p> <p>The PD was interviewed on 10/28/15 at 4:00 PM and stated, "I didn't elaborate with the notes," and indicated he had instructed staff to use the wheelchair or call the on-call supervisor if client C fell. He indicated he had demonstrated how client C was to be lifted under his arms and how to use the wheelchair. The PD stated, "Sometimes his legs don't work," and stated "We would use a sling (gait belt)" and had demonstrated its use at the meeting. The PD indicated staff #7 and #8 had not attended the meeting and there was no additional training since client C's fall on 10/23/15.</p> <p>The AD was interviewed on 11/2/15 at 5:20 PM and indicated the nurse should have noticed a pattern of client C's falls and addressed them.</p> <p>2. A BDDS report dated 6/11/15 indicated client B was taken on the evening of 6/10/15 for evaluation of a pressure ulcer and indicated client B would be taken to the wound center for follow up treatment.</p> <p>Client B's records were reviewed on 10/27/15 at 1:25 PM. A wound care</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>clinic note dated 6/19/15 indicated client B's treatment of his pressure ulcer was complete and he could return as needed. Client B's Risk Plan updated 4/13/14 indicated he was at risk for impaired skin integrity including pressure ulcers and staff were trained to document injuries to the skin in Therap. Client B's Skin/Wound Assessments from 9/1/15-10/27/15 indicated client B had a pressure ulcer on 9/14/15 10 cm (centimeters) by 8 cm.</p> <p>A nursing assessment dated 10/27/15 at 9:19 PM indicated client B was assessed by the nurse at the AD 's request and found no open areas on his skin. There was no evidence of a nursing assessment of client B 's wound prior to 10/27/15 and after he was diagnosed with a pressure ulcer on 6/10/15.</p> <p>The nurse indicated on 11/5/15 at 12:17 PM the staff would be retrained on documenting in the skin/wound module for client B.</p> <p>3. A BDDS report dated 9/8/15 indicated client D was taken to the ER and diagnosed with a UTI (urinary tract infection) and possible ear infection and was admitted to the hospital for IV (intravenous) antibiotic therapy.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>Corrective action indicated the facility would continue to follow physician ' s orders upon discharge.</p> <p>A BDDS report dated 10/8/15 indicated client D was taken to the ER and diagnosed with a UTI and required the use of IV antibiotics to treat the infection. Corrective action indicated staff were to take client D to an urgent care center immediately if they suspect he had a UTI.</p> <p>Client D's records were reviewed on 10/28/15 at 11:20 AM. A Risk Plan dated 5/25/15 indicated client D had a risk of urinary retention which placed him at risk for a UTI. Prevention included " Staff are trained in the signs of urinary retention. Elimination is tracked in he use of Therap (digital/electronic record keeping system) in the Intake/Elimination module...Staff are to report any of the signs of urinary retention immediately to the RC (residential coordinator/PC) (pain with urination, difficulty or inability to urinate, blood in the urine and abdominal distention. Client D had a risk of prostate gland enlargement which can block the flow of urine. Staff are to report any concerns to supervisor who will consult with nurse/MD (medical doctor)."</p> <p>Client D's September, 2015 medication administration record (MAR) in the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>record failed to indicate client D was catheterized on 9/6/15 or on 9/20/15 at 6:00 AM. The instructions indicated staff were to " Insert Straight Catheter as per training instructions and enter the amount (if any) in Health Tracking (Therap). If no output of urine, when cathed (sic) (catheterized) within 3 days call RC. If [client D] produces urine when cathed, mark as a 'void' along with the amount in Health Tracking."</p> <p>Client D's October, 2015 MAR indicated staff failed to document client D was catheterized on 10/3, 10/4, and 10/12/15 at 6:00 AM.</p> <p>Client D's Intake and Elimination Daily Data Forms for September 2015-October, 2015 in the record indicated there was no documentation of client D's output on 9/5-/6/15 and no documentation for client D's output for 10/3-10/14/15.</p> <p>The group home nurse was interviewed on 11/5/15 at 1:54 PM and indicated staff were supposed to document when client D was catheterized and to record the results and indicated the documentation is inaccurate or missing. She indicated the nurse should be reviewing the data on a daily basis.</p> <p>This federal tag relates to complaint</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 11/09/2015	
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012			
(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			
W 0249 Bldg. 00	<p>#IN00185516.</p> <p>9-3-3(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review and interview for 1 additional client (client F), the facility failed to implement the behavior plan as written.</p> <p>Findings include:</p> <p>Observations were completed on 10/27/15 from 7:10 AM until 8:38 AM. At 7:40 AM, client F indicated he was not going to work. Staff #4 stated, "You have to go. You can't stay home," and "Do you want a snack at night? Do you</p>	W 0249	<p>W 249 Program Implementation As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>1. What corrective action will be accomplished? · The Program Coordinator will do home observations weekly to</p>	12/09/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 11/09/2015
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012		
(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>want a brownie?"</p> <p>Client F's records were reviewed on 10/27/15 at 1:16 PM. A Behavior Support Plan (BSP) dated 7/14/15 indicated targeted behaviors of inappropriate social behaviors, noncompliance, inappropriate verbal behavior, physical aggression, property misuse and AWOL (away without leave). Interventions for noncompliance indicated staff should ask client F one time to comply with a necessary request. "If he does not respond, staff should refer him to his schedule and remind him that he would like to be more independent...If [client F] does not comply with the request within 2 minutes, staff should give another prompt without emotion. Staff should simply say, '[Client F] you need to ____.' Nothing further should be said. Staff should not lecture, plead, counsel or reprimand [client F] in any way, as this will likely give him the attention he enjoys...."</p> <p>The Area Director was interviewed on 11/2/15 at 5:20 PM and indicated client F's plan should have been implemented to address his noncompliance and staff should not have used a directive tone or snacks as an intervention.</p> <p>9-3-4(a)</p>		<p>ensure staff are implementing the plans of clients and the client's needs are being met.</p> <ul style="list-style-type: none"> · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: <ul style="list-style-type: none"> o Behavior plans and/or documentation expectations for Clients A-H o Staff approach · Staff #4 was retrained on Client F's behavior plan by the Behavior Clinician on 11-4-15. · The Behavior Clinician will complete monthly observations or more frequent based on the client's behavioral support needs to ensure staff is implementing the behavior plan appropriately and that the plan is still effective. <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 Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>plans of clients and the client's needs are being met.</p> <ul style="list-style-type: none"> · Training completed with the staff regarding: <ul style="list-style-type: none"> o Behavior plans and/or documentation expectations for Clients A-H o Staff approach · The Behavior Clinician will complete monthly observations or more frequent based on the client's behavioral support needs to ensure staff is implementing the behavior plan appropriately and that the plan is still effective. · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. <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 Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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
			<ul style="list-style-type: none"> o Behavior plans and/or documentation expectations for Clients A-H o Staff approach <ul style="list-style-type: none"> · The Behavior Clinician will complete monthly observations or more frequent based on the client's behavioral support needs to ensure staff is implementing the behavior plan appropriately and that the plan is still effective. · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. <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 to ensure the clients plans and needs are being met during their bi-weekly observations. · The Program Coordinator will monitor to ensure the clients plans and needs are being met during their weekly observations. · The Behavior Clinician will complete monthly observations or more frequent based on the client's behavioral support needs to ensure staff is implementing the behavior plan appropriately and that the plan is still effective. · New staff hired to work at the site will receive client specific training for each individual prior to 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/09/2015
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012		
(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>working a shift. This training includes items such as: client's diets, risk plans, ISP's, BSP's, programming, and medication review.</p> <ul style="list-style-type: none"> · The nurse will be available to do observations within the home for medical related issues as the client's needs indicate. · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · Monthly supervisory visit check sheets to be completed by the QIDP. These will be forwarded to the Area Director for review. · Quarterly Health and Safety assessments will be completed by the Program Coordinator and/or the Program Director and forwarded to the Quality Improvement department. These assessments include a review of the environmental needs for the home, review of risk plans, ISP, BSP and client specific training for the residents. The assessment also includes an interview of staff to ensure they know how to properly document medical needs, how to report incidents, diets and understanding of BSP's. <p>5. What is the date by which the systemic changes will be completed? December 9th, 2015</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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
--------------------	--	---------------	---	----------------------

W 0268 Bldg. 00	<p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT</p> <p>These policies and procedures must promote the growth, development and independence of the client.</p> <p>Based on observation, record review and interview, the facility failed to ensure staff used a positive approach when interacting with clients for 1 of 4 sampled clients (client C) and 3 additional clients (clients E, F and H).</p> <p>Findings include:</p> <p>1. Observations were completed on 10/27/15 from 7:10 AM until 8:38 AM. At 7:40 AM, client F indicated he was not going to work. Staff #4 stated in a directive tone, "You have to go. You can't stay home," and "Do you want a snack at night? Do you want a brownie?"</p> <p>Client F's records were reviewed on 10/27/15 at 1:16 PM. A Behavior Support Plan (BSP) dated 7/14/15 indicated targeted behaviors of inappropriate social behaviors, noncompliance, inappropriate verbal behavior, physical aggression, property misuse and AWOL (away without leave). Interventions for noncompliance indicated staff should ask client F one time to comply with a necessary request. "If he does not respond, staff should refer</p>	W 0268	<p>W 268 Conduct Toward Client</p> <p>These policies and procedures must promote the growth, development and independence of the client.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: <ul style="list-style-type: none"> o Behavior plans and/or documentation expectations for Clients A-H o Staff approach o Active treatment expectations (competency test provided) · Staff #4 was retrained on Client F's behavior plan by the Behavior Clinician on 11-4-15. · The Behavior Clinician will complete monthly observations or more frequent based on the client's behavioral support needs to ensure staff is implementing the behavior plan appropriately and that the plan is still effective. 	12/09/2015
--------------------	---	--------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>him to his schedule and remind him that he would like to be more independent...If [client F] does not comply with the request within 2 minutes, staff should give another prompt without emotion. Staff should simply say, '[Client F] you need to ____.' Nothing further should be said. Staff should not lecture, plead, counsel or reprimand [client F] in any way, as this will likely give him the attention he enjoys...."</p> <p>The Area Director was interviewed on 11/2/15 at 5:20 PM and indicated client F's plan should have been implemented to address his noncompliance and staff should not have used a directive tone or snacks as an intervention.</p> <p>2. Observations were completed at the group home on 10/26/15 from 5:55 PM until 7:06 PM. Client C sat on his bed and asked staff #7 to assist him in removing his hospital bracelets, with the exception of the bracelet labeled "fall risk," which he wanted to remain attached to his wrist.</p> <p>The Program Coordinator (PC) was interviewed on 10/26/15 at 6:00 PM and stated client C had returned from the hospital "a couple of hours ago." He indicated client C had fallen on 10/23/15 and may have had the flu.</p>		<ul style="list-style-type: none"> · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. 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 Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: <ul style="list-style-type: none"> o Behavior plans and/or documentation expectations for Clients A-H o Staff approach o Active treatment expectations (competency test provided) · The Behavior Clinician will complete monthly observations or more frequent based on the client's behavioral support needs to ensure staff is implementing the behavior plan appropriately and that the plan 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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 E was interviewed on 10/26/15 at 6:30 PM and stated staff #8 "Is demanding. I know this is our house, but I feel like it's not our house." Client E stated client C had been "pushed" by staff #8 causing his fall on 10/23/15.</p> <p>Client C was interviewed on 10/26/15 at 6:31 PM. He stated staff #8 had "pushed me as in rushed. I fell flat on my face." When asked how staff #8 rushed him, client C stated, "Hurry up, we're going to be late. We were outside and I was about to get on the bus."</p> <p>Client F was interviewed on 10/26/15 at 6:20 PM and stated staff #15 "bosses me around," and staff #15 would tell client F to "Get this done." When asked if he had informed anyone, he indicated he had told the PC (Program Coordinator) who was standing in the area.</p> <p>The PC was interviewed on 10/26/15 at 6:20 PM and indicated he had been made aware of clients E and F's concerns of staff #8's approach earlier that week (date not specified) and was going to address it with staff #8.</p> <p>Staff #4 was interviewed on 10/27/15 at 7:40 AM and stated she had heard clients complain about staff #8 "bossing "</p>		<p>is still effective.</p> <ul style="list-style-type: none"> · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · The Program Director/QIDP will review all client ISP's with the staff as they are completed on a yearly basis or more frequently as the needs arise. <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 Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: <ul style="list-style-type: none"> o Behavior plans and/or documentation expectations for Clients A-H o Staff approach o Active treatment expectations (competency test provided) · The Behavior Clinician will complete monthly observations or more frequent based on the client's 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 11/09/2015
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012		
(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>clients. She indicated staff #8 was sometimes directive in requests and she had attempted to demonstrate how to ask clients to complete tasks by asking them " Could you please? "</p> <p>The Area Director (AD) was interviewed on 10/27/15 at 12:20 PM and indicated staff #8 was currently suspended due to an allegation made by client F that morning of misconduct.</p> <p>A Summary of Internal Investigation Report dated 11/4/15 for an incident dated 10/29/15 indicated on 10/29/15, the AD suspended staff #8 for "being bossy." The following interviews were completed as part of the investigation:</p> <p>Client C was interviewed (undated) and indicated he was walking to the bus and "his legs just gave out on him ([client C] fell going to the van on 10/29/15...Stated he felt rushed because [staff #8] was telling everyone to hurry up...Stated he doesn't like [staff #8] because he wakes me up on (sic) the morning and doesn't wake everyone else up on the morning. Stated he feels like this is [staff #8] being bossy. States an example of [staff #8] being bossy is 'Pushy, meaning talking to me real fast, telling me to hurry up. Stated [staff #8] has only been bossy on</p>		<p>behavioral support needs to ensure staff is implementing the behavior plan appropriately and that the plan is still effective.</p> <ul style="list-style-type: none"> · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · The Program Director/QIDP will review all client ISP's with the staff as they are completed on a yearly basis or more frequently as the needs arise. <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 to ensure the clients plans and needs are being met during their bi-weekly observations. · The Program Coordinator will monitor to ensure the clients plans and needs are being met during their weekly observations. · The Behavior Clinician will complete monthly observations or more frequent based on the client's behavioral support needs to ensure staff is implementing the behavior plan appropriately and that the plan is still effective. · New staff hired to work at the site will receive client specific training for each individual prior to working a shift. This training includes items such as: client's diets, 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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 day he [client C] fell when he had the walker...."</p> <p>Client B's undated interview indicated staff #8 was not bossy to him, but "sometimes [staff #8] is bossy to [client H]."</p> <p>Client E's undated interview indicated "things are not going good because [staff #8] is irritating...Stated he doesn't like the way [staff #8] speaks to them and he feels like he's in the military. Stated [staff #8] is bossy to everybody. Stated [staff #8] has yelled at him and raised his voice but could not give specifics...."</p> <p>Client F's undated interview indicated " things are not going good because of [staff #8]. Stated [staff #8] is bossy. Stated [staff #8] will go into his bedroom and hook his phone up to the surround sound in my bedroom. Stated he wants to get rid of [staff #8]. " Staff #8 " demands " client F to wash the table as part of his assigned chores and staff #8 has yelled at him and raised his voice. When asked if [staff #8] has been physically abusive towards him states, 'yes, he punches his hand. ' "</p> <p>Staff #4's undated interview indicated "she had never seen [staff #8] be bossy towards clients."</p>		<p>risk plans, ISP's, BSP's, programming, and medication review.</p> <ul style="list-style-type: none"> · The nurse will be available to do observations within the home for medical related issues as the client's needs indicate. · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · Monthly supervisory visit check sheets to be completed by the QIDP. These will be forwarded to the Area Director for review. · Quarterly Health and Safety assessments will be completed by the Program Coordinator and/or the Program Director and forwarded to the Quality Improvement department. These assessments include a review of the environmental needs for the home, review of risk plans, ISP, BSP and client specific training for the residents. The assessment also includes an interview of staff to ensure they know how to properly document medical needs, how to report incidents, diets and understanding of BSP's. · New staff hired to work at the site will receive client specific training for each individual prior to working a shift. This training includes items such as: client's diets, risk plans, ISP's, programming, and medication review. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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 PD's undated interview indicated "Stated the clients he spoke to said if a female were to ask in the same manner and tone as [staff #8] it would not be a problem. "</p> <p>Staff #8's undated interview indicated "Stated he just wakes them up and lets them know from time to time they are running behind, but he has never been bossy or mean to them."</p> <p>The conclusion indicated " evidence does not support the allegation of verbal abuse from [client F] involving [staff #8], and [staff #8] will be retrained on how to speak to clients. "</p> <p>9-3-5(a)</p>		<p>5. What is the date by which the systemic changes will be completed? December 9th, 2015</p>	
--	---	--	---	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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
W 0318 Bldg. 00	<p>483.460 HEALTH CARE SERVICES</p> <p>The facility must ensure that specific health care services requirements are met.</p> <p>Based upon observation, record review and interview, the facility failed to meet the Condition of Participation: Health Care Services. The facility's health care services failed for 3 of 4 sampled clients (clients B, C and D) to develop and implement a system to document, monitor, and develop corrective action after a series of falls involving client C resulting in injury, hospital visits and requiring the use of emergency medical personnel to assist client C after falling. The facility's nursing services failed to monitor to ensure staff accurately documented implementation of clients B and D risk plans to address pressure ulcers (client B) and urinary tract infections (client D) resulting in hospitalization.</p> <p>Findings include:</p> <p>1. The facility's health care services failed to develop and implement a system to document, monitor, and develop corrective action after a series of falls involving client C resulting in injury, hospital visits and requiring the use of emergency medical personnel to assist</p>	W 0318	<p>W 318 Health Care Services</p> <p>The facility must ensure that specific health care services requirements are met.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: <ul style="list-style-type: none"> ○ How to measure wounds ○ How to document skin/wound findings ○ How to document falls ○ When to contact the Program Coordinator ○ Training regarding the risk plans and health needs for Clients B, C and D. ○ How to monitor and document intake and elimination ○ How to properly cath Client D · The Program Coordinator and Program Director will be retrained on the appointment process expectations, following physician 	12/09/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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 C after falling. The facility's nursing service failed to monitor to ensure staff accurately documented implementation of clients B and D's risk plans to address pressure ulcers (client B) and urinary tract infections (client D) resulting in hospitalization. Please see W331.</p> <p>2. The facility's health care services failed to ensure staff were trained to competency on reporting and documenting the health needs of 3 of 4 sampled clients (clients B, C and D). Please see W192.</p> <p>This federal tag relates to complaint #IN00185516.</p> <p>9-3-6(a)</p>		<p>recommendations and communication expectations with the nurse.</p> <ul style="list-style-type: none"> · The Program Coordinator and Program Director will be retrained on the expectations for the medical charts. · The new nurse will be at the site weekly to help oversee the medical needs of the residents and complete assessments as needed. · The medical charts for the site have been reviewed by the nurse. · The IDT is currently meeting weekly to address Client C's health care needs. The IDT will continue to monitor his needs and may change the need to meet weekly as his health care needs improve and/or stabilize. · Client C has been participating in Physical Therapy services within the home. · Client C now has a walker, patient lift, gait belt, mat for his floor, audible monitor, motion alarm, bed rails and a wheelchair to assist in preventing falls. · Client C has had one on one supervision to assist in fall prevention. The IDT continues to monitor the need for this level of supervision to continue. The IDT will make recommendations for this supervision to change as his health care needs improve and/or stabilize. · Client C will participate in programming to help him understand the need to use his adaptive equipment and to complete his physical therapy exercises. · Client C now has a C-pap 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>machine in place.</p> <ul style="list-style-type: none"> · Client C is participating in 15 minute checks throughout the night to monitor the use of his C-pap machine. · Client C was seen by his psychiatrist on 10-29-15 to monitor his psych needs. He will see the psychiatrist again in January or sooner if needed. · Client C continues to see his counselor to help address his mental health needs. · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · Daily nursing oversight for Client C was completed through 11-24-15. · Currently the nurse is assessing Client C three times a week. The IDT will continue to monitor the need for this level of supervision to continue. The IDT will make recommendations for this supervision to change as his health care needs improve and/or stabilize. · Client B, C and D's risk plans will be reviewed by the nurse. Revisions will be implemented as necessary. · Program Coordinator/QIDP/nurse oversight of the MAR's, intake/elimination and skin/wound documentation (daily basis Program Coordinator) and 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>when in the home (QIDP and nurse) to ensure it is completed and holes are addressed appropriately.</p> <ul style="list-style-type: none"> · A new nurse is currently going through training. The importance of documenting her assessments accurately and ongoing will be addressed. · The nurse will be trained on how to follow up with physician recommendations to ensure they are implemented and/or addressed by the IDT. · Client D has a scheduled urology appointment on 12-21-15. · Formal programming to be implemented for Client D on reporting symptoms of a UTI. · Competency training with the nurse was completed with staff on 10-28 and 10-29-15 which included one person transfers, two person transfers, use of a gait belt, wheelchair safety, and one person assist. · Training was completed by the nurse on 10-29-15 included body mechanics/safe transfers, updated fall risk plan for Client C, adaptive equipment and change in health status reporting. · The nurse will monitor staff documentation at a minimum of weekly and communicate with the necessary team members as needed. · The nurse will conduct quarterly staff observations to ensure continued competency over adaptive equipment, body mechanics/safe transfers. · Client Specific training for 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>new staff will include body mechanics/safe transfers and the use of a gait belt.</p> <ul style="list-style-type: none"> · The Program Coordinator will check adaptive equipment weekly to ensure compliance. · Client C's ISP will be updated to reflect his current needs. · The IDT will monitor trends and patterns in client reportable incidents. The IDT will convene as necessary to discuss an increase in reportable incidents such as falls. · In the event that Client B has a pressure sore, the nurse will monitor and/or assess Client B on at least a weekly basis until the sore has resolved. · Client B currently does not have a pressure sore. <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 Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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
			<ul style="list-style-type: none"> o How to measure wounds o How to document skin/wound findings o How to document falls o When to contact the Program Coordinator o Training regarding the risk plans and health needs for Clients B, C and D. o How to monitor and document intake and elimination o How to properly cath Client D <ul style="list-style-type: none"> · The Program Coordinator and Program Director will be retrained on the appointment process expectations, following physician recommendations and communication expectations with the nurse. · The Program Coordinator and Program Director will be retrained on the expectations for the medical charts. · The new nurse will be at the site weekly to help oversee the medical needs of the residents and complete assessments as needed. · The medical charts for the site have been reviewed by the nurse. · The IDT will continue to monitor the needs of all of the clients. The IDT will convene to address and monitor the health care needs of the residents until they improve and/or stabilize. · The need for adaptive equipment for the residents will be reviewed. In the event that additional adaptive equipment is needed the IDT will obtain it per physician recommendations. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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
			<ul style="list-style-type: none"> · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · All resident risk plans will be reviewed by the nurse. Revisions will be implemented as necessary. · Program Coordinator/QIDP/nurse oversight of the MAR's, intake/elimination and skin/wound documentation (daily basis Program Coordinator) and when in the home (QIDP and nurse) to ensure it is completed and holes are addressed appropriately. · A new nurse is currently going through training. The importance of documenting her assessments accurately and ongoing will be addressed. · The nurse will be trained on how to follow up with physician recommendations to ensure they are implemented and/or addressed by the IDT. · Competency training with the nurse was completed with staff on 10-28 and 10-29-15 which included one person transfers, two person transfers, use of a gait belt, wheelchair safety, and one person assist. · Training was completed by the nurse on 10-29-15 included body mechanics/safe transfers, updated fall risk plan for Client C, adaptive equipment and change in health 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>status reporting.</p> <ul style="list-style-type: none"> · The nurse will monitor staff documentation at a minimum of weekly and communicate with the necessary team members as needed. · The nurse will conduct quarterly staff observations to ensure continued competency over adaptive equipment, body mechanics/safe transfers. · Client Specific training for new staff will include body mechanics/safe transfers and the use of a gait belt. · The Program Coordinator will check adaptive equipment weekly to ensure compliance. · The IDT will monitor trends and patterns in client reportable incidents. The IDT will convene as necessary to discuss an increase in reportable incidents such as falls. <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 Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: <ul style="list-style-type: none"> o How to measure wounds 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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
			<ul style="list-style-type: none"> o How to document skin/wound findings o How to document falls o When to contact the Program Coordinator o Training regarding the risk plans and health needs for Clients B, C and D. o How to monitor and document intake and elimination o How to properly cath Client D <ul style="list-style-type: none"> · The Program Coordinator and Program Director will be retrained on the appointment process expectations, following physician recommendations and communication expectations with the nurse. · The Program Coordinator and Program Director will be retrained on the expectations for the medical charts. · The new nurse will be at the site weekly to help oversee the medical needs of the residents and complete assessments as needed. · The medical charts for the site have been reviewed by the nurse. · The IDT will continue to monitor the needs of all of the clients. The IDT will convene to address and monitor the health care needs of the residents until they improve and/or stabilize. · The need for adaptive equipment for the residents will be reviewed. In the event that additional adaptive equipment is needed the IDT will obtain it per physician recommendations. · The IDT has implemented 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			<p>monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment.</p> <ul style="list-style-type: none"> · All resident risk plans will be reviewed by the nurse. Revisions will be implemented as necessary. · Program Coordinator/QIDP/nurse oversight of the MAR's, intake/elimination and skin/wound documentation (daily basis Program Coordinator) and when in the home (QIDP and nurse) to ensure it is completed and holes are addressed appropriately. · A new nurse is currently going through training. The importance of documenting her assessments accurately and ongoing will be addressed. · The nurse will be trained on how to follow up with physician recommendations to ensure they are implemented and/or addressed by the IDT. · Competency training with the nurse was completed with staff on 10-28 and 10-29-15 which included one person transfers, two person transfers, use of a gait belt, wheelchair safety, and one person assist. · Training was completed by the nurse on 10-29-15 included body mechanics/safe transfers, updated fall risk plan for Client C, adaptive equipment and change in health status reporting. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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
			<ul style="list-style-type: none"> · The nurse will monitor staff documentation at a minimum of weekly and communicate with the necessary team members as needed. · The nurse will conduct quarterly staff observations to ensure continued competency over adaptive equipment, body mechanics/safe transfers. · Client Specific training for new staff will include body mechanics/safe transfers and the use of a gait belt. · The Program Coordinator will check adaptive equipment weekly to ensure compliance. · The IDT will monitor trends and patterns in client reportable incidents. The IDT will convene as necessary to discuss an increase in reportable incidents such as falls. <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 to ensure the clients plans and needs are being met during their bi-weekly observations. · The Program Coordinator will monitor to ensure the clients plans and needs are being met during their weekly observations. · Mentor's nurse will be in the home on a weekly basis or more frequently as needed to monitor for concerns and assess residents. · New staff hired to work at the site will receive client specific training for each individual prior to working a shift. This training 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>includes items such as: client's diets, risk plans, ISP's, programming, and medication review.</p> <ul style="list-style-type: none"> · The nurse will be available to do observations within the home for medical related issues as the client's needs indicate. · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · Monthly supervisory visit check sheets to be completed by the QIDP. These will be forwarded to the Area Director for review. · Oversight of the MAR, intake/elimination, and skin/wound documentation will be completed by the Program Coordinator, QIDP, and nurse. · Quarterly Health and Safety assessments will be completed by the Program Coordinator and/or the Program Director and forwarded to the Quality Improvement department. These assessments include a review of the environmental needs for the home, review of risk plans, ISP, BSP and client specific training for the residents. The assessment also includes an interview of staff to ensure they know how to properly document medical needs, how to report incidents, diets and understanding of BSP's. <p>5. What is the date by which the</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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
W 0331 Bldg. 00	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based upon observation, record review and interview, facility's health care services failed to develop and implement a system to document, monitor, and develop corrective action after a series of falls involving client C resulting in injury, hospital visits and requiring the use of emergency medical personnel to assist client C after falling. The facility's nursing services failed to monitor to ensure staff accurately documented implementation of clients B and D's risk plans to address pressure ulcers (client B) and urinary tract infections (client D) resulting in hospitalization.</p> <p>Findings include:</p> <p>Observations were completed at the group home on 10/26/15 from 5:55 PM until 7:06 PM. Client C sat on his bed and asked staff #7 to assist him in removing his hospital bracelets, with the exception of the bracelet labeled "fall risk," which he wanted to remain attached to his wrist.</p> <p>The Program Coordinator (PC) was</p>	W 0331	<p>systemic changes will be completed?</p> <p>W 331 Nursing Services The facility must provide clients with nursing services in accordance with their needs.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: <ul style="list-style-type: none"> ○ How to measure wounds ○ How to document skin/wound findings ○ How to document falls ○ When to contact the Program Coordinator ○ Training regarding the risk plans and health needs for Clients B, C and D. ○ How to monitor and document intake and elimination ○ How to properly cath Client D · The Program Coordinator and Program Director will be retrained on the appointment process 	12/09/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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 10/26/15 at 6:00 PM and stated client C had returned from the hospital "a couple of hours ago." He indicated client C had fallen on 10/23/15 and may have had the flu.</p> <p>Staff #10 was interviewed on 10/26/15 at 5:55 PM and indicated client C had a history of falls and staff used a gait belt to assist him.</p> <p>Client E was interviewed on 10/26/15 at 6:30 PM and stated client C had been "pushed" by staff #8 causing his fall on 10/23/15.</p> <p>Client C was interviewed on 10/26/15 at 6:31 PM. He stated staff #8 had "pushed me as in rushed. I fell flat on my face." When asked how staff #8 rushed him, client C stated, "Hurry up, we're going to be late. We were outside and I was about to get on the bus."</p> <p>Staff #4 was interviewed on 10/26/15 at 6:50 PM and stated client C "is hard to supervise. He has fallen recently. The meds he's on make him drowsy-when he falls it's hard to catch him." Staff #4 indicated client C had a fall risk plan to use a gait belt and a walker. Staff #4 indicated if client C falls, staff were to call the HM (house manager)/PC and indicated emergency medical services</p>		<p>expectations, following physician recommendations and communication expectations with the nurse.</p> <ul style="list-style-type: none"> · The Program Director will be retrained on the role and expectations of the QIDP. · The Program Director will be retrained on the IDT process. · The Program Coordinator and Program Director will be retrained on the expectations for the medical charts. · The new nurse will be at the site weekly to help oversee the medical needs of the residents and complete assessments as needed. · The medical charts for the site have been reviewed by the nurse. · The IDT is currently meeting weekly to address Client C's health care needs. The IDT will continue to monitor his needs and may change the need to meet weekly as his health care needs improve and/or stabilize. · Client C has been participating in Physical Therapy services within the home. · Client C now has a walker, patient lift, gait belt, mat for his floor, audible monitor, motion alarm, bed rails and a wheelchair to assist in preventing falls. · Client C has had one on one supervision to assist in fall prevention. The IDT continues to monitor the need for this level of supervision to continue. The IDT will make recommendations for this supervision to change as his health care needs improve and/or stabilize. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>staff had to assist with client C to get up after falls twice on 10/23/15. Staff #4 indicated she not been present when client C had fallen and had been able to stop him from falling by asking him to stand up straight.</p> <p>Observations were completed again at the group home on 10/27/15 from 7:10 AM until 8:38 AM. Staff #8 assisted client C to get up from his bed using a gait belt. Client C used a rolling walker to go to the kitchen and sat on a wooden kitchen chair. Staff #8 and #9 assisted client C to get up from the chair using a gait belt and to use his walker. Staff #9 showed staff #8 how to position the gait belt for client C and how to position client C to his walker to aid him in rising from the chair. Client C requested a wooden chair to sit on in the living room and sat on the chair without arms with his head slumped toward his chest and his eyes closed. Client C's color was pale and of a yellow tint, and he aroused and indicated he was tired. Staff #9 assisted client C using a gait belt and asked him to count to 3 and stand using his walker. Client C stood up and used his walker to walk to his room. Staff #9 instructed client C to keep his walker close to him while he walked for stability and to assist him in standing straighter and complimented him on his ability to stand.</p>		<ul style="list-style-type: none"> · Client C will participate in programming to help him understand the need to use his adaptive equipment and to complete his physical therapy exercises. · Client C now has a C-pap machine in place. · Client C is participating in 15 minute checks throughout the night to monitor the use of his C-pap machine. · Client C was seen by his psychiatrist on 10-29-15 to monitor his psych needs. He will see the psychiatrist again in January or sooner if needed. · Client C continues to see his counselor to help address his mental health needs. · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · Daily nursing oversight for Client C was completed through 11-24-15. · Currently the nurse is assessing Client C three times a week. The IDT will continue to monitor the need for this level of supervision to continue. The IDT will make recommendations for this supervision to change as his health care needs improve and/or stabilize. · Client B, C and D's risk plans will be reviewed by the nurse. Revisions will be implemented as 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>Staff #8 and #9 were interviewed on 10/27/15 at 7:25 AM. Staff #9 indicated she was a CNA (certified nursing assistant).</p> <p>Staff #8 indicated he had not been trained on specific client interventions for client C, and client C had been found on the floor of his bedroom at 3:00 AM on 10/23/15 when he was working with staff #7 on the overnight shift. He indicated client C normally got up at 4:00 AM for his shower to give him extra time. He indicated he and staff #7 had attempted to get client C up using the gait belt, but weren't able to get him up. Staff #8 indicated he had called 911 and on-call staff, and due to the emergency (with client C on the floor) the fire department had arrived to assist client C to get up. Staff #8 stated, client C "went on with his day and showered. My shift was over and I was off the clock. I was walking him out and I don't know if he missed his step (on the driveway) or missed his footing, and I tried to stop it (fall). He's a pretty good sized guy-my size and just the momentum...we called 911 and then the HM (house manager)/PC. I told the HM I could leave, staff were here with him. I don't know what happened as I left. I normally clock out at 8:00 AM, it was after that."</p>		<p>necessary.</p> <ul style="list-style-type: none"> · Program Coordinator/QIDP/nurse oversight of the MAR's, intake/elimination and skin/wound documentation (daily basis Program Coordinator) and when in the home (QIDP and nurse) to ensure it is completed and holes are addressed appropriately. · A new nurse is currently going through training. The importance of documenting her assessments accurately and ongoing will be addressed. · The nurse will be trained on how to follow up with physician recommendations to ensure they are implemented and/or addressed by the IDT. · Client D has a scheduled urology appointment on 12-21-15. · Formal programming to be implemented for Client D on reporting symptoms of a UTI. · Competency training with the nurse was completed with staff on 10-28 and 10-29-15 which included one person transfers, two person transfers, use of a gait belt, wheelchair safety, and one person assist. · Training was completed by the nurse on 10-29-15 included body mechanics/safe transfers, updated fall risk plan for Client C, adaptive equipment and change in health status reporting. · The nurse will monitor staff documentation at a minimum of weekly and communicate with the necessary team members as needed. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>Staff #7 was interviewed on 10/27/15 at 8:20 AM. Staff #7 stated client C was currently asleep in his room, client C was better 2-3 weeks ago and has been "like this for a week." Staff #7 indicated client C had been experiencing medication adjustments. Staff #7 indicated she had been present when client C fell on 10/23/15 on the overnight shift and at 9:00 AM. She saw client C fall as she went around the back of the van to assist with the lift. She stated staff #8 "was right in front of him. He was walking to his car to leave and was not assisting [client C]." Staff #7 indicated client C took about 30 minutes to leave the kitchen to get to the van on the morning of 10/23/15 prior to his fall and was not rushed. She indicated she had not received client specific training for client C to assist him using the gait belt or address his falls.</p> <p>Client C's discharge orders from the hospital were reviewed on 10/26/15 at 6:28 PM. The discharge orders indicated client C's clonazepam was reduced to 5 mg (milligrams) from 10 mg. There was no other information in regards to client C's diagnosis or instructions to address client C's follow up care.</p> <p>The facility's reports to the Bureau of</p>		<ul style="list-style-type: none"> · The nurse will conduct quarterly staff observations to ensure continued competency over adaptive equipment, body mechanics/safe transfers. · Client Specific training for new staff will include body mechanics/safe transfers and the use of a gait belt. · The Program Coordinator will check adaptive equipment weekly to ensure compliance. · Client C's ISP will be updated to reflect his current needs. · The IDT will monitor trends and patterns in client reportable incidents. The IDT will convene as necessary to discuss an increase in reportable incidents such as falls. · In the event that Client B has a pressure sore, the nurse will monitor and/or assess Client B on at least a weekly basis until the sore has resolved. · Client B currently does not have a pressure sore. <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 Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 11/09/2015
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012		
(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>Developmental Disabilities Services were reviewed on 10/27/15 at 10:15 AM and included the following for client C:</p> <p>A BDDS report dated 5/8/15 indicated on 5/8/15 at 6:25 AM, client C fell during his shower. Staff reported client C bruised his bottom (size and specific location not indicated). Client C later stated, "that he may have hit his head when falling. PC (Program Coordinator) contacted the nurse consultant and was advised to take [client C] to the ER (emergency room). Corrective action indicated the PC would follow recommendations of (sic) nurse consultant and ER physician. Staff will continue to monitor for any changes and report concerns immediately."</p> <p>A BDDS report dated 10/3/15 indicated client C "was having chest pains and thought he was having a heart attack so staff called the ambulance were (sic) he was taken to the hospital and treated. Hospital stated he was having an (sic) just pains and gave him tylenol. Hospital staff stated if chest pain continues after 3 to 4 days then go see his doctor." Corrective action indicated "Staff will continue to follow mentor (sic) policy as stated."</p> <p>A BDDS report dated 10/7/15 indicated</p>		<p>home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met.</p> <ul style="list-style-type: none"> · Training completed with the staff regarding: <ul style="list-style-type: none"> o How to measure wounds o How to document skin/wound findings o How to document falls o When to contact the Program Coordinator o Training regarding the risk plans and health needs for Clients B, C and D. o How to monitor and document intake and elimination o How to properly cath Client D o Review the supervision needs for Client A · The Program Coordinator and Program Director will be retrained on the appointment process expectations, following physician recommendations and communication expectations with the nurse. · The Program Director will be retrained on the role and expectations of the QIDP. · The Program Director will be retrained on the IDT process. · The Program Coordinator and Program Director will be retrained on the expectations for the medical charts. · The new nurse will be at the site weekly to help oversee the medical needs of the residents and complete assessments as needed. · The medical charts for the site 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 11/09/2015	
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012			
(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 10/7/15 at 7:10 PM, client C was found by the staff on the bedroom floor, "staff tried to help [client C] up, other client (unspecified) called ambulance, ambulance came and helped [client C] up, there appears to be no injury, but staff will continue to check throughout the shift." Corrective action indicated "Follow Mentors (sic) policy and Procedure on Falls."</p> <p>A BDDS report written by the PD dated 10/23/15 was reviewed on 10/23/15 at 12:20 PM and indicated at 9:00 AM, client C "was walking to the bus lift where his legs gave out and he fell chest first into (sic) the driveway. i (sic) evaluated him, no blood, did not loose (sic) consciousness, complained of pain in both wrist (sic), both legs, and in his face and right eye, called ambulance. [Client C] was taken to the hospital and kept for an overnight observation. Corrective action indicated "Follow Mentors (sic) policy on falls."</p> <p>An investigation into the incident on 10/23/15 dated 10/24/15 was reviewed on 10/27/15 at 12:20 PM and indicated the same information as provided in the BDDS report in regards to the incident. Staff #7, client C and the PC were interviewed as part of the investigation. Staff #7 indicated in her interview she</p>		<p>have been reviewed by the nurse.</p> <ul style="list-style-type: none"> · The IDT will continue to monitor the needs of all of the clients. The IDT will convene to address and monitor the health care needs of the residents until they improve and/or stabilize. · The need for adaptive equipment for the residents will be reviewed. In the event that additional adaptive equipment is needed the IDT will obtain it per physician recommendations. · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · All resident risk plans will be reviewed by the nurse. Revisions will be implemented as necessary. · Program Coordinator/QIDP/nurse oversight of the MAR's, intake/elimination and skin/wound documentation (daily basis Program Coordinator) and when in the home (QIDP and nurse) to ensure it is completed and holes are addressed appropriately. · A new nurse is currently going through training. The importance of documenting her assessments accurately and ongoing will be addressed. · The nurse will be trained on how to follow up with physician recommendations to ensure they are implemented and/or addressed by the 				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 11/09/2015	
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012			
(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>was in the process of taking the clients out to the bus so they could go to day services. The interview indicated staff #7 stated "Everything was fine until [client C] just fell all of a sudden, [client C] told her his legs just give (sic) out and they don't want to work right sometimes, he was complaining about his wrist and legs hurting and that she called the Ambulance, the PC just pulled up." The PC indicated he had just pulled up to the group home and found that client C had just fallen. The PC indicated he went with client C to the hospital and the nurse wanted to keep client C overnight to run tests. Client C was interviewed and stated, "he was walking to the bus and his legs just gave out on him, his legs stops (sic) working from time to time and he was in some pain and wanted to go to the hospital." There was no evidence any other clients present were interviewed as part of the investigation into client C's fall on the driveway at 9:00 AM on 10/23/15.</p> <p>A Preliminary Report of Alleged Adult Endangerment was reviewed on 10/28/15 at 9:30 AM and indicated " On 10/26/15 APS (Adult Protective Services) received the following report: ...Please see the attached police report from [county] regarding [client C] (Victim). Victim (client C) is mentally handicapped.</p>		<p>IDT.</p> <ul style="list-style-type: none"> · Competency training with the nurse was completed with staff on 10-28 and 10-29-15 which included one person transfers, two person transfers, use of a gait belt, wheelchair safety, and one person assist. · Training was completed by the nurse on 10-29-15 included body mechanics/safe transfers, updated fall risk plan for Client C, adaptive equipment and change in health status reporting. · The nurse will monitor staff documentation at a minimum of weekly and communicate with the necessary team members as needed. · The nurse will conduct quarterly staff observations to ensure continued competency over adaptive equipment, body mechanics/safe transfers. · Client Specific training for new staff will include body mechanics/safe transfers and the use of a gait belt. · The Program Coordinator will check adaptive equipment weekly to ensure compliance. · The IDT will monitor trends and patterns in client reportable incidents. The IDT will convene as necessary to discuss an increase in reportable incidents such as falls. <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>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>Victim resides in a group home believed to be under the supervision of REM-Indiana Mentor/Occazio ...According to the police report, [client C] is around 5' (feet) 10" (inches) and weighs over 300 lbs (pounds). Officer [name] states in her report that this is the second time in two weeks that she has been to the home due to Victim falling in the driveway. The first occurrence was on 10/15/15. Also Officer [name] was advised that the [township name] Fire Department was out on Victim around 4:00 (AM/PM not specified) on this date, 10/23/15 due to victim falling out of bed. There is concern over a lack of staff or supervision at the group home to assist Victim and also inadequate equipment to accommodate Victim " An attached police report indicated a Case Narrative " On 10/23/15, I assisted with [township] Fire Department on an injured (sic) in a fall at [group home address]. This is a group home. This is the second time in 2 weeks that I have been to the group home in regards to the same client falling in the driveway. The prior incident was 10/15/15. I was advised the fire department was requested around 04:00 on 10/23/15 due to [client C] falling out of bed. I was advised the fire department assisted [client C] in standing.</p> <p>On 10/15/15, [client C] had fell (sic) in</p>		<ul style="list-style-type: none"> · The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: <ul style="list-style-type: none"> o How to measure wounds o How to document skin/wound findings o How to document falls o When to contact the Program Coordinator o Training regarding the risk plans and health needs for Clients B, C and D. o How to monitor and document intake and elimination o How to properly cath Client D o Review the supervision needs for Client A · The Program Coordinator and Program Director will be retrained on the appointment process expectations, following physician recommendations and communication expectations with the nurse. · The Program Director will be retrained on the role and expectations of the QIDP. · The Program Director will be retrained on the IDT process. · The Program Coordinator and Program Director will be retrained on the expectations for the medical 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 11/09/2015
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012		
(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 driveway. [Client C] is approximately 5'10" and weighs over 300 pounds. The fire department assisted [client C] in standing and getting him back into a van. The fire department requested a wheelchair due to the distance the van was due to where [client C] fell. A wheelchair was brought out from the facility that would not be large enough for a large adult let alone a client that is obese as [client C]. On this occasion [client C] was unsteady on his feet and was unable to walk without assistance. The fireman had to place each of [client C 's] legs into the van. The (sic) they had to push on his bottom to move him over so that the door would close. [Client C] attempted to assist but trembled as he tried to move his own weight. There was a small bus that was picking up some of the clients. It is my understanding that [client C] would have to climb the stairs in order to get on the small bus. The bus is equipped with a ramp. One of the fireman (sic) advised that someone from the group home advised that there has not had (sic) a manager for some time. They also advised that the clients are shipped from this facility to another due to being understaffed during the daytime. The staff was little to no help in getting [client C] on the van.</p> <p>On 10/23/15, [client C] was lying face</p>		<p>charts.</p> <ul style="list-style-type: none"> · The new nurse will be at the site weekly to help oversee the medical needs of the residents and complete assessments as needed. · The medical charts for the site have been reviewed by the nurse. · The IDT will continue to monitor the needs of all of the clients. The IDT will convene to address and monitor the health care needs of the residents until they improve and/or stabilize. · The need for adaptive equipment for the residents will be reviewed. In the event that additional adaptive equipment is needed the IDT will obtain it per physician recommendations. · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · All resident risk plans will be reviewed by the nurse. Revisions will be implemented as necessary. · Program Coordinator/QIDP/nurse oversight of the MAR's, intake/elimination and skin/wound documentation (daily basis Program Coordinator) and when in the home (QIDP and nurse) to ensure it is completed and holes are addressed appropriately. · A new nurse is currently going through training. The importance of documenting her 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>down on the driveway, which is a slight decline. His face was toward the downward slope and facing opposite of the house. [Client C] had a blanket draped over him, but he was shaking. I spoke to [client C] and he complained of pain to his head. There was no blood or obvious injuries that I could see. [Client C] stated the staff tell him it is his fault that he falls because he gets in too big of a hurry. A walker was close to [client C]. One of the fire personnel advised the walker appeared to be too small for the size of [client C].</p> <p>I overheard one of the staff say his medication was changed and there should be improvements.</p> <p>The concern in if the equipment for [client C] is adequate for his size, as well as if there is adequate staff to deal with [client C ' s] needs. [Client C] is a mentally disabled individual and may not be able to adequately express his needs or provide for himself to attain what he needs. " There was a note at the bottom of the report "Forward to Adult Protective Services. "</p> <p>There was no evidence in reports provided by the facility the incident of client C falling on October 15, 2015 had been reported to the administrator,</p>		<p>assessments accurately and ongoing will be addressed.</p> <ul style="list-style-type: none"> · The nurse will be trained on how to follow up with physician recommendations to ensure they are implemented and/or addressed by the IDT. · Competency training with the nurse was completed with staff on 10-28 and 10-29-15 which included one person transfers, two person transfers, use of a gait belt, wheelchair safety, and one person assist. · Training was completed by the nurse on 10-29-15 included body mechanics/safe transfers, updated fall risk plan for Client C, adaptive equipment and change in health status reporting. · The nurse will monitor staff documentation at a minimum of weekly and communicate with the necessary team members as needed. · The nurse will conduct quarterly staff observations to ensure continued competency over adaptive equipment, body mechanics/safe transfers. · Client Specific training for new staff will include body mechanics/safe transfers and the use of a gait belt. · The Program Coordinator will check adaptive equipment weekly to ensure compliance. · The IDT will monitor trends and patterns in client reportable incidents. The IDT will convene as necessary to discuss an increase in reportable incidents such as falls. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>BDDS, investigated or of corrective action taken to address client C' s fall.</p> <p>Client C's record was reviewed on 10/27/15 at 12:55 PM. A visit to client C's primary care physician dated 9/14/15 indicated client C weighed 333.9 pounds in 4/15. There were no other records found to indicate client C's weight. There was no evidence of an updated Individual Support Plan since his last ISP dated 3/4/15.</p> <p>A Risk Plan updated on 10/27/15 and previously updated on 10/14/11 indicated client C's risks included, but were not limited to medication side effects, depression, Intermittent Explosive Disorder, Personality Disorder, Obesity, Phlebitis (blood clots), warfarin (blood thinner/anti-coagulant) therapy, and history of falls. Client C's risk for warfarin therapy indicated "Warfarin can cause very serious (possibly fatal) bleeding." Client C's falls risk indicated he "has a history of falls and at risk for falls. [Client C] is to be using w/c (wheelchair) and gait belt PRN (as needed) for increased unsteady gait. Staff are to ensure environment free from fall hazards (rugs, cords, etc), if fall occurs assessment to be completed and PC/PD to be phoned regarding fall. If (sic) sustains injury that appears severe/life</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 Program Director will monitor to ensure the clients plans and needs are being met during their bi-weekly observations. · The Program Coordinator will monitor to ensure the clients plans and needs are being met during their weekly observations. · Mentor's nurse will be in the home on a weekly basis or more frequently as needed to monitor for concerns and assess residents. · New staff hired to work at the site will receive client specific training for each individual prior to working a shift. This training includes items such as: client's diets, risk plans, ISP's, programming, a 	
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/09/2015	
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012			
(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>threatening in nature, they are to initiate EMS (emergency medical services) prior to notification of PC/PD. Obtain vitals and document accordingly." The plan failed to indicate how many staff were to assist client C in using the gait belt, transferring or specific information as to when client C was to use the wheelchair and gait belt and how staff were to assist him with the adaptive equipment. The plan failed to indicate the use of client C's rolling walker.</p> <p>IDT (interdisciplinary) meeting notes on 10/16/15 in client C's record entered by the Behavior Analyst (BA) indicated client C "has been observed falling asleep, having difficulty walking, standing, getting out of bed." The note indicated client C's psychiatrist nurse practitioner (NP) had "increased Seroquel (anti-psychotic) from 400 mg (milligrams) daily to 400 mg BID (twice daily), changed Depakote (seizures/mood stability) from 2,000 mg at bedtime to 1,000 mg BID, changed Clonazepam (anxiety) from 1 mg BID to 1 mg TID (three times daily), added Zyprexa Zydis 5 mg PRN (as needed) for agitation on September 16, 2015. After med (medication) change, staff nurse, [name] stated [client C] had increased his falls over the weekend and contacted [client C's] [primary care physician (PCP)] to</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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
	request a med decrease of Seroquel. [PCP], decreased Seroquel back to 400 mg daily-other psych med changes made by [NP] were continued. Even after dosage change of Seroquel, [client C] displays frequent difficulty ambulating requiring the fire department to be contacted three times during the month of October to assist staff in helping [client C] get up/ambulate. [Client C] has also been taken to the ER twice since his admission due to reports he was having a heart attack on one occasion and reports he was having difficulty walking on the second occasion-no medical confirmation was made at either ER visit. [Client C] had some med changes that occurred at the nursing home prior to his admission to the group home on September 11, 2015. Said changes that included Provigil discontinued and Keppra added. [Client C] has completed labs to check Depakote and ammonia levels. [Client C] has also recently completed a sleep study. We do not currently have lab results or sleep study results...Recommendations: 1) PC/PD will schedule an appt (appointment) with [PCP] to address: recommendations regarding Provigil (medication to increase alertness); recommendations regarding need for Keppra (seizures); discuss results and get copies from sleep study; request order for wheelchair PRN; discuss order for use of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>gait belt at all times except when [client C] is seated in his wheelchair and in bed; request order for OT (occupational therapy)/PT (physical therapy) evaluation; request an order for new ted hose (support stockings). 2) PC/PD will begin a 24 hr (hour) sleep chart so [client C's] sleeping can be tracked at the day service and the group home. 3) PC/PD will contact the lab facility to request copies of [client C's] recent labs-results will be scanned to therap (electronic/digital recording system). 4) [Client C's] level of agitation and threats of physical harm to others has decreased since he has had increased medical issues-it is recommended by the staff nurse [name], that staff refrain from using the Zyprexa Zydys PRN medication as [client C] is not currently a physical harm to others. If staff question [client C's] agitation and feel he is a threat to himself or others, the PC/PD should be contacted...."</p> <p>Client C's MAR (medication administration record) dated 10/2015 failed to indicate a sleep chart for client C, the use of a wheelchair or of a rolling walker. The MAR indicated client C's gait belt may be used prn (as needed). The MAR indicated the use of clonazepam .5 mg twice daily and listed the side effect of drowsiness, depakote</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>ER (extended release) 2,000 mg, with a side effect of drowsiness, Keppra (seizures) 500 mg twice daily with a side effect of drowsiness, weakness and dizziness, perphenazine (psychosis) 6 mg with side effects of dizziness, drowsiness and anxiety, Seroquel (anti-psychosis) 400 mg daily with a side effect of drowsiness, and warfarin 6 mg daily and Zyprexa Zydis 5 mg (anti-psychotic) every 8 hours as needed.</p> <p>A General Event Report (GER) in client C's record dated 5/18/15 indicated in the section Event Information "Describe what happened before the event: don't know, client says it happened this morning when another peer was helping him up from the floor...Comments: client says he couldn't get up off the floor, asked him if he fell out of bed, he said trying to get out of bed and slid to floor. Told me staff was aware..." The sections for Corrective Action Taken, Plan of Future Corrective Actions and Follow-Up actions, were blank. The report indicated the residential manager (PC) was notified by staff #2 on 5/18/15 at 8:31 PM. The PD (Program Director)/QIDP (Qualified Intellectual Disabilities Professional) reviewed the report on 5/19/15 at 9:50 AM. There was no evidence the incident was reported to the Area Director or the group home nurse was notified of the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>incident. There was no evidence in the report of an assessment to determine if client C was injured during the incident.</p> <p>A GER dated 6/2/15 indicated client C "was sick last night, staff monitored all night. [Client C] got up this morning and was not feeling well still, had high temp (temperature) (not specified) and low O2 (oxygen level in the blood stream). He was taken to doctor and sent to the emergency room...Comments: [client C] was admitted into the emergency room because of his condition, as of 3 pm he was being admitted into the ICU (intensive care unit)." There was no corrective action or follow up listed in the report. A BDDS report attached to the GER indicated on 6/2/15 at 11:30 AM, client C was taken to the hospital after being sick all night with a high temperature and low O2 saturations. Corrective action indicated "I told the staff to do the same thing if he complains about it a lot, then take him to the hospital. So we would use the same plan as before."</p> <p>T-Log nursing notes were reviewed on 10/28/15 at 9:50 AM and indicated on 10/6/15, "Called and spoke with [PD] on Sunday regarding [client C], stated hospital states did not have a heart attack, give tylenol as needed. Checked up on</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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 C] on Monday (date not specified), he appeared tired from increase in psych (psychotropic) meds (medications) but was alert and able to carry on conversatin (sic), c/o (complains of) knees hurting, no other distress noted." The note failed to indicate any follow up action to address client C's chest pain, appearance of being tired or of his knee pain.</p> <p>A note from the nurse dated 10/7/15 indicated PD "notified order received last night to decrease seroquel to 400 mg (milligrams) daily due to lethargy. Called [primary care physician's] office and requested new script for calcium citrate and fax order for seroquel decrease. Client more alert today...."</p> <p>A nursing note dated 10/9/15 indicated "Client refused body assessment, states, 'I'm OK,' called [primary care physician's] office 2nd time and asked about new script for calcium citrate, awaiting orders."</p> <p>A nursing note dated 10/12/15 indicated client C "continues to deny any injuries from fall, denies any further pain in his chest, c/o right knee pain, no swelling noted, left thumb healing, nail healing and coming off, no s/sx (symptoms) of infection, area pink, no swelling noted."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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 nursing note dated 10/26/15 at 12:38 PM indicated a social worker at the hospital wanted to talk to her about PT (physical therapy) for client C. The note indicated he would be referred to a home health agency to evaluate and treat client C's needs. The social worker "further advised he will be discharged today-I requested records from his stay be sent with staff upon discharge so we may have in his chart and she advised she would ensure a packet would be made and sent. She could not advise as to any changes in medication. PD/AD/PC advised of above and requested to schedule follow up with [PCP] immediately."</p> <p>A note dated 10/27/15 at 9:15 AM indicated "Upon review of discharge orders it is noted that perphenazine and warafin (sic) orders are changed as well. I phoned [Hospital] and spoke with [name] who was working on floor [client C] was on...." The discussion with the nurse at the hospital indicated client C's warfarin (blood thinner) and perphenazine were to be continued as they were upon admission at 6 mg daily warfarin and 6 mg TID of perphenazine. The note indicated client C was to be scheduled for PT evaluation within 48 hours and the PC was aware. The note indicated client C was to see his PCP on 11/2/15.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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 nursing note dated 10/27/15 indicated client C was assessed and when awakened, indicated he was OK. Client C's vital signs were normal and the nurse noted client C was "somewhat lethargic during assessment but could have just been tired."</p> <p>Additional T-Log nursing notes were reviewed on 10/28/15 at 3:50 PM. A nursing note dated 10/28/15 at 2:51 PM indicated client C was sleeping, but awakened easily. "He was independent in undressing and transferring to his w/c wheelchair...Staff commented that [client C] was more alert and mobile than he has been recently...."</p> <p>A note dated 10/28/15 at 3:08 PM indicated client C was being referred for a CPAP (continuous pressure airway machine) and client C's PCP had sent orders for PT evaluation and treatment and had requested an order for a wheelchair and gait belt for "safety purposes."</p> <p>A nursing note dated 10/28/15 at 3:12 PM indicated the nurse had checked on another client and while at the group home, checked on client C, "I was surprised to see him up and alert and oriented a totally different person that I</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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 assessed 4 hours earlier...."</p> <p>A Polysomnography Report (evaluation of sleep quality) was reviewed on 10/27/15 at 11:45 AM and indicated client C had been diagnosed with "severe obstructive sleep apnea with significant oxygen desaturations," with a total of 305 respiratory events and a calculated apnea (stopping and starting sleep)/hypoxia (lack of oxygen) was 50 events per hour. Client C had an oxygen saturation below 89% for a total of 150 minutes. The report indicated a recommendation to use a CPAP machine to aid in preventing airway obstruction during sleep.</p> <p>A Mayo Clinic website mayoclinic.org reviewed on 10/29/15 at 2:30 PM indicated sleep apnea is a "potentially serious sleep disorder in which breathing repeatedly stops and starts." A side effect listed on the website indicated tiredness even after a full night's sleep.</p> <p>Indiana Mentor Meeting Notes dated 10/19/15 indicated "Discussed falls with [client C] and how to get him up in the morning." There was no additional evidence of specific information in regards to how staff were to assist client C to get up in the morning. Staff present at the meeting included the PC, staff #6, staff #3, staff #4 and day services</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>coordinator #1. There was no evidence staff #2, #5, #7, #8 or #9 as listed on the staff list provided at the entrance of the survey were present or had been provided information from the meeting.</p> <p>The group home nurse was interviewed on 10/27/15 at 11:30 AM and indicated she had just transferred to the group home on 10/26/15 and the Area Director (AD) should be able to provide evidence of staff training for client C's updated risk plan.</p> <p>The AD and Regional Director were interviewed on 10/28/15 at 3:40 PM and indicated client C's risk plan should be specific as to how staff were to use the gait belt, when to use the wheelchair and walker and how to assist client C if he were to fall.</p> <p>An electronic/digital message sent to all staff working in the group home dated 10/27/15 at 2:21 PM was reviewed on 10/28/15 at 3:53 PM and indicated client C "is to remain in his wheelchair at all times per hospital orders until further notice." There was no evidence of a physician's order for the use of client C's wheelchair or of staff training to use the wheelchair, transferring client C, assisting him in using the gait belt or what to do if client C fell.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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 AD was interviewed on 10/28/15 at 3:53 PM and indicated there was no evidence staff had not been trained on client C's plan updated on 10/27/15.</p> <p>The PD was interviewed on 10/28/15 at 4:00 PM and stated, "I didn't elaborate with the notes," and indicated he had instructed staff to use the wheelchair or call the on-call supervisor if client C fell. He indicated he had demonstrated how client C was to be lifted under his arms and how to use the wheelchair. The PD stated, "Sometimes his legs don't work," and stated "We would use a sling (gait belt)" and had demonstrated its use at the meeting. The PD indicated staff #7 and #8 had not attended the meeting and there was no additional training since client C's fall on 10/23/15.</p> <p>The AD was interviewed on 11/2/15 at 5:20 PM and indicated the nurse should have noticed a pattern of client C's falls and addressed them.</p> <p>2. A BDDS report dated 6/11/15 indicated client B was taken on the evening of 6/10/15 for evaluation of a pressure ulcer and indicated client B would be taken to the wound center for follow up treatment.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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 B's records were reviewed on 10/27/15 at 1:25 PM. A wound care clinic note dated 6/19/15 indicated client B's treatment of his pressure ulcer was complete and he could return as needed. Client B's Risk Plan updated 4/13/14 indicated he was at risk for impaired skin integrity including pressure ulcers and staff were trained to document injuries to the skin in Therap. Client B's Skin/Wound Assessments from 9/1/15-10/27/15 indicated client B had a pressure ulcer on 9/14/15 10 cm (centimeters) by 8 cm.</p> <p>A nursing assessment dated 10/27/15 at 9:19 PM indicated client B was assessed by the nurse at the AD ' s request and found no open areas on his skin. There was no evidence of a nursing assessment of client B ' s wound prior to 10/27/15 and after he was diagnosed with a pressure ulcer on 6/10/15.</p> <p>The nurse indicated on 11/5/15 at 12:17 PM the staff would be retrained on documenting in the skin/wound module for client B.</p> <p>3. A BDDS report dated 9/8/15 indicated client D was taken to the ER and diagnosed with a UTI (urinary tract infection) and possible ear infection and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>was admitted to the hospital for IV (intravenous) antibiotic therapy. Corrective action indicated the facility would continue to follow physician ' s orders upon discharge.</p> <p>A BDDS report dated 10/8/15 indicated client D was taken to the ER and diagnosed with a UTI and required the use of IV antibiotics to treat the infection. Corrective action indicated staff were to take client D to an urgent care center immediately if they suspect he had a UTI.</p> <p>Client D's records were reviewed on 10/28/15 at 11:20 AM. A Risk Plan dated 5/25/15 indicated client D had a risk of urinary retention which placed him at risk for a UTI. Prevention included "Staff are trained in the signs of urinary retention. Elimination is tracked in the use of Therap (digital/electronic record keeping system) in the Intake/Elimination module...Staff are to report any of the signs of urinary retention immediately to the RC (residential coordinator/PC) (pain with urination, difficulty or inability to urinate, blood in the urine and abdominal distention. Client D had a risk of prostate gland enlargement which can block the flow of urine. Staff are to report any concerns to supervisor who will consult with nurse/MD (medical doctor)."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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 D's September, 2015 medication administration record (MAR) in the record failed to indicate client D was catheterized on 9/6/15 or on 9/20/15 at 6:00 AM. The instructions indicated staff were to "Insert Straight Catheter as per training instructions and enter the amount (if any) in Health Tracking (Therap). If not output of urine, when cathed (sic) (catheterized) within 3 days call RC. If [client D] produces urine when cathed, mark as a 'void' along with the amount in Health Tracking."</p> <p>Client D ' s October, 2015 MAR indicated staff failed to document client D was catheterized on 10/3, 10/4, and 10/12/15 at 6:00 AM.</p> <p>Client D ' s Intake and Elimination Daily Data Forms for September, 2015-October, 2015 in the record indicated there was no documentation of client D ' s output on 9/5-/6/15 and no documentation for client D ' s output for 10/3-10/14/15.</p> <p>The group home nurse was interviewed on 11/5/15 at 1:54 PM and indicated staff were supposed to document when client D was catheterized and to record the results and stated the documentation is inaccurate or missing. She indicated the nurse should be reviewing the data on a</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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
W 0460 Bldg. 00	<p>daily basis.</p> <p>This federal tag relates to complaint #IN00185516.</p> <p>9-3-6(a)</p> <p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, record review and interview, the facility failed to provide 4 of 4 sampled clients (clients A, B, C and D) and 4 of 4 additional clients (clients E, F, G and H) with well-balanced diets, and failed to ensure there was adequate food in the home to provide specified menu choices.</p> <p>Findings include:</p> <p>Observations at the group home were completed on 10/27/15 from 7:10 AM until 8:38 AM. Client C ate a cinnamon roll and beverage. No other food items were offered for the breakfast meal. An</p>	W 0460	<p>W 460 Food and Nutrition Services Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. 	12/09/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>uneaten partial pan of rolls was on the kitchen counter.</p> <p>The menu for the week dated week 3 fall/winter was reviewed on 10/27/15 at 8:00 AM and indicated 3/4 cup of apple juice, 3/4 cup of whole grain cereal or 1/2 cup of cereal of choice, 2 slices of whole wheat toast, 1 tsp (teaspoon) of margarine, 1 boiled egg, 1 cup of water, coffee/tea as desired and 1 cup of skim milk or 1/2 % milk.</p> <p>Staff #4 was interviewed on 10/27/15 at 8:05 AM and indicated there was no food in the house listed on the menu except cereal and stated, "They had that yesterday." She indicated clients A, B, D, E, F, G and H had already eaten their breakfast of cinnamon rolls.</p> <p>The contents of the refrigerator, freezer and pantry shelves were observed on 10/27/15 at 8:05 PM and indicated there were 8 eggs, 2 containers of biscuits, 1 inch remaining in a gallon of milk, 2 containers of buttermilk biscuits, 3 cans of frozen fruit punch, 3 plastic containers of cereal, 7 potatoes, 3 onions, and 1 zip closed 1 pound plastic container of sliced frozen chicken meat.</p> <p>The Program Director was interviewed on 10/29/15 at 7:30 AM. When asked</p>		<ul style="list-style-type: none"> · Training completed with the staff regarding: <ul style="list-style-type: none"> o Client's A-H diets o Following the menus o Use of the food substitution logs · The Program Coordinator will be trained on how to follow dietary guidelines for the residents, menus for the group home, shopping according to the menus, using the food substitution logs, and ensuring there is enough food in the home. <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 Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: <ul style="list-style-type: none"> o Client's A-H diets o Following the menus o Use of the food substitution logs · The Program Coordinator will be trained on how to follow dietary guidelines for the residents, menus for the group home, shopping according to the menus, using the 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>about adequate food in the home, he indicated there should be adequate food and he supplied the staff with funds to purchase enough food for menus.</p> <p>9-3-8(a)</p>		<p>food substitution logs, and ensuring there is enough food in the home.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: <ul style="list-style-type: none"> o Client's A-H diets o Following the menus o Use of the food substitution logs · The Program Coordinator will be trained on how to follow dietary guidelines for the residents, menus for the group home, shopping according to the menus, using the food substitution logs, and ensuring there is enough food in the home. <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 to ensure the clients plans and needs are being met during their bi-weekly observations. · The Program Coordinator will monitor to ensure the clients plans and needs are being met during their 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/09/2015
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012		
(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	
W 0488 Bldg. 00	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her		<p>weekly observations.</p> <ul style="list-style-type: none"> · Mentor's nurse will be in the home on a weekly basis or more frequently as needed to monitor for concerns and assess residents. · New staff hired to work at the site will receive client specific training for each individual prior to working a shift. This training includes items such as: client's diets, risk plans, ISP's, programming, and medication review. · Monthly supervisory visit check sheets to be completed by the QIDP. These will be forwarded to the Area Director for review. · Quarterly Health and Safety assessments will be completed by the Program Coordinator and/or the Program Director and forwarded to the Quality Improvement department. These assessments include a review of the environmental needs for the home, review of risk plans, ISP, BSP and client specific training for the residents. The assessment also includes an interview of staff to ensure they know how to properly document medical needs, how to report incidents, diets and understanding of BSP's. <p>5. What is the date by which the systemic changes will be completed? December 9th, 2015</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>developmental level.</p> <p>Based on observation and interview, the facility failed to encourage 4 of 4 sampled clients (clients A, B, C and D) and 4 of 4 additional clients (clients E, F, G and H) to participate in the preparation of meals.</p> <p>Findings include:</p> <p>Observations were completed at the group home on 10/29/15 from 6:38 AM until 7:30 AM. Staff #4 prepared the breakfast of fried eggs, toast, milk and juice without assistance from clients A, B, C, D, E, F, G and H or prompting clients to assist. Staff #4 set the table for client C while client G and the PD discussed seasoning for eggs.</p> <p>The Program Director was interviewed on 10/29/15 at 7:30 AM. When asked about clients assisting in cooking, he indicated he had not noticed the clients failed to participate in cooking.</p> <p>The Area Director was interviewed on 11/2/15 at 5:20 PM and indicated clients should be assisting in preparing their meals.</p> <p>9-3-8(a)</p>	W 0488	<p>W 488 Dining Areas and Service</p> <p>The facility must ensure that each client eats in a manner consistent with his or her developmental level.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: <ul style="list-style-type: none"> o Active treatment expectations (competency test provided) · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · Formal programming will be implemented for Clients A-H regarding meal prep and setting the table. <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 	12/09/2015
--	---	--------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>potential to be affected by the same deficient practice.</p> <ul style="list-style-type: none"> · The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: <ul style="list-style-type: none"> o Active treatment expectations (competency test provided) · The Program Director/QIDP will ensure that there is formal programming in place for all residents that address identified needs. · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. <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 Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met.</p> <ul style="list-style-type: none"> · Training completed with the staff regarding: <ul style="list-style-type: none"> o Active treatment expectations (competency test provided) · The Program Director/QIDP will ensure that there is formal programming in place for all residents that address identified needs. · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. <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 to ensure the clients plans and needs are being met during their bi-weekly observations. · The Program Coordinator will monitor to ensure the clients plans and needs are being met during their weekly observations. · Mentor's nurse will be in the home on a weekly basis or more frequently as needed to monitor for concerns and assess residents. · New staff hired to work at the site will receive client specific training for each individual prior to working a shift. This training 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012
---	--

(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>includes items such as: client's diets, risk plans, ISP's, programming, and medication review.</p> <ul style="list-style-type: none"> · The IDT has implemented monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · Monthly supervisory visit check sheets to be completed by the QIDP. These will be forwarded to the Area Director for review. · The QIDP will monitor and review the resident's needs. As the needs arise, formal programming will be implemented. · Quarterly Health and Safety assessments will be completed by the Program Coordinator and/or the Program Director and forwarded to the Quality Improvement department. These assessments include a review of the environmental needs for the home, review of risk plans, ISP, BSP and client specific training for the residents. The assessment also includes an interview of staff to ensure they know how to properly document medical needs, how to report incidents, diets and understanding of BSP's. <p>5. What is the date by which the systemic changes will be completed? December 9th, 2015</p>	