

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G342	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/31/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OCCAIO INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1650 E JEFFERSON ST FRANKLIN, IN 46131
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W0000	<p>This visit was for the investigation of complaint #IN00122022.</p> <p>This visit was in conjunction with a post certification revisit to the recertification and state licensure survey completed on 11/20/12.</p> <p>Complaint #IN00122022: Unsubstantiated, due to lack of sufficient evidence.</p> <p>Unrelated deficiencies cited.</p> <p>Survey Dates: January 29, 30 and 31, 2013.</p> <p>Facility Number: 000858 Provider Number: 15G342 AIM Number: 100244140</p> <p>Surveyor: Steven Schwing, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/5/13 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		

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

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G342		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/31/2013	
NAME OF PROVIDER OR SUPPLIER OCCAZIO INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1650 E JEFFERSON ST FRANKLIN, IN 46131			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W0104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, interview and record review for 8 of 8 clients living in the group home (A, B, C, D, E, F, G and H), the governing body failed to ensure there was a policy/procedure for staff to implement in regard to a medication found on the floor.</p> <p>Findings include:</p> <p>An observation was conducted on 1/29/13 from 3:03 PM to 4:50 PM. At 4:13 PM after staff #7 administered client H's medications, the surveyor observed a pill on the floor underneath a rolling office chair. The pill matched the color (peach) and markings (L and 4) of client F's Levothyroxine. Client F's medication pass occurred at 3:34 PM and he was to receive Levothyroxine from staff #4. The surveyor was not informed staff #4 was administering client F's medication therefore client F's medication pass was not observed.</p> <p>An interview was conducted with the Residential Coordinator (RC) on 1/30/13 at 10:31 AM. The RC indicated she spoke to staff #4 on 1/29/13. Staff #4 indicated client F received his</p>	W0104	<p>W 104 Governing Body</p> <p>The governing body 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"> · Procedures for finding a dropped pill will be reviewed with staff at their team meeting on 2-26-13. · Occazio's medication administration policy will be reviewed with staff at their team meeting on 2-26-13. · A medication practicum will be completed with Staff #4 by 3-2-13 to ensure they are following proper medication administration guidelines. <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p>	03/02/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G342	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/31/2013
NAME OF PROVIDER OR SUPPLIER OCCAZIO INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1650 E JEFFERSON ST FRANKLIN, IN 46131		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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>Levothyroxine. The RC indicated staff #4 indicated the pill was not dropped on the floor. The RC indicated she did not know if client F received his medication on 1/29/13. The RC indicated she did not contact the nurse. The RC indicated she was unable to determine when the pill was dropped.</p> <p>An interview with the Area Residential Coordinator (ARC) was conducted on 1/30/13 at 10:34 AM. The ARC indicated the nurse would be contacted when there was a known medication error. The ARC indicated there was not a procedure to implement for a found medication.</p> <p>An interview with the nurse was conducted on 1/30/13 at 2:31 PM. The nurse indicated she should have been notified. The nurse indicated she would have contacted client F's physician to give him the information regarding what the facility found regarding the pill found on the floor. The nurse indicated there should be a policy addressing the steps staff should take when a pill was found.</p> <p>9-3-1(a)</p>		<ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · Procedures for finding a dropped pill will be reviewed with staff at their team meeting on 2-26-13. · Occazio's medication administration policy will be reviewed with staff at their team meeting on 2-26-13. · Random medication practicums will be completed with staff to ensure they are following proper medication administration guidelines. <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"> · Procedures for finding a dropped pill will be reviewed with staff at their team meeting on 2-26-13. · Occazio's medication administration policy will be reviewed with staff at their team meeting on 2-26-13. · Random medication practicums will be completed with staff to ensure they are following proper medication administration 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G342	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/31/2013
NAME OF PROVIDER OR SUPPLIER OCCAZIO INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1650 E JEFFERSON ST FRANKLIN, IN 46131		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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>guidelines.</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 RC will monitor on a daily basis when they are in the home. · The Program Specialist will monitor as they complete their audits. · The RN will monitor as they complete their audits. <p>5. What is the date by which the systemic changes will be completed?</p> <p>March 2, 2013</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G342	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/31/2013
NAME OF PROVIDER OR SUPPLIER OCCAZIO INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1650 E JEFFERSON ST FRANKLIN, IN 46131		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 3 of 15 incident/investigative reports reviewed affecting clients C, D, F and H, the facility neglected to implement its policies and procedures for reporting incidents of client to client abuse to the Bureau of Developmental Disabilities Services (BDDS).</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 1/29/13 at 9:44 AM. The following incidents were not reported to BDDS:</p> <ol style="list-style-type: none"> On 1/6/13 at 5:30 PM, clients H and F were "flipping each other off." Client H yelled profanities at client F. Client F threw a cup of milk at client H. Client H ran over and held the cup to client F's neck causing a scratch on the right side of client F's neck. On 12/17/12 at 3:25 PM, Client D threw a cup of juice at client H. Client D was prompted to leave the area. Client D went around the table and hit client C on the back. Client C had a red area on her left shoulder blade. 	W0149	<p>W 149 Staff Treatment of Clients</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> All incidents of peer to peer aggression will be reported to BDDS and other officials in accordance with State law through established procedures. The need to report and investigate all peer to peer incidents will be reviewed with the Residential Coordinator by 3-2-13. Staff will be retrained on Client's C, D, F and H behavior plans during their team meeting on 2-26-13. Staff will be retrained on ways to prevent peer to peer aggression incidents during their team meeting on 2-26-13. 	03/02/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G342		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/31/2013	
NAME OF PROVIDER OR SUPPLIER OCCAZIO INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1650 E JEFFERSON ST FRANKLIN, IN 46131			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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. On 12/8/12 at 3:45 PM, client F exited the medication room and "flipped [client H] off." Client F threw water on client H. Client H jumped up and went toward client F. Client H grabbed client F's shirt. The report indicated, "Blows were thrown by both clients." Client H had a scratch under his right eye and was bleeding. Client F had 2 small cuts on the inside of his bottom lip.</p> <p>A review of the facility's policy and procedure, dated 1/1/11, was conducted on 1/30/13 at 3:30 PM. The policy indicated, "Occazio, Inc. will not tolerate mistreatment, abuse, neglect or exploitation of any Occazio resident/consumer. Employees who witness any form of abuse, neglect or exploitation or have a reason to believe that abuse, neglect or exploitation has occurred (see definitions below), must report the incident(s) to their immediate supervisor and observe the procedures outlined below. Physical abuse- any violent or physical act which may injure a person. Some examples include but are not limited to: striking, dragging, shoving, kicking, punching and deprivation. Physical abuse also includes the use of corporal punishment and any unauthorized restrictive, intrusive procedure to control behavior, cause behavior or punish. The Residential</p>		<ul style="list-style-type: none"> · Programming has been put in place for Client's C, D, F and H on managing their anger. <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. · All incidents of peer to peer aggression will be reported to BDDS and other officials in accordance with State law through established procedures. · The need to report and investigate all peer to peer incidents will be reviewed with the Residential Coordinator by 3-2-13. · Staff will be retrained on the residents behavior plans during their team meeting on 2-26-13. · Staff will be retrained on ways to prevent peer to peer aggression incidents during their team meeting on 2-26-13. 				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G342	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/31/2013
NAME OF PROVIDER OR SUPPLIER OCCAZIO INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1650 E JEFFERSON ST FRANKLIN, IN 46131		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 for the injured party or the Residential Coordinator on call will report by internet all allegations of abuse, neglect or exploitation to Adult Protective Services (APS) and the District and Central offices of the Bureau of Developmental Disabilities Services (BDDS) within 24 hours of receipt of the Occazio employee's (or other individual's) initial report of abuse, neglect or exploitation."</p> <p>An interview with the Residential Coordinator (RC) was conducted on 1/30/13 at 10:27 AM. The RC indicated the facility was not reporting to BDDS peer to peer aggression unless there was significant injury until recently. The RC indicated the facility was following the BDDS guidelines.</p> <p>An interview with the Area Residential Coordinator (ARC) was conducted on 1/30/13 at 10:27 AM. The ARC indicated the facility was directed on 1/28/13 to report to BDDS all incidents of peer to peer aggression.</p> <p>9-3-2(a)</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"> · All incidents of peer to peer aggression will be reported to BDDS and other officials in accordance with State law through established procedures. · The need to report and investigate all peer to peer incidents will be reviewed with the Residential Coordinator by 3-2-13. · Staff will be retrained on the residents behavior plans during their team meeting on 2-26-13. · Staff will be retrained on ways to prevent peer to peer aggression incidents during their team meeting on 2-26-13. <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · The RC will monitor on a daily basis when they are in the home. · The Program Specialist will monitor as they complete their audits. 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G342	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/31/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OCCAZIO INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1650 E JEFFERSON ST FRANKLIN, IN 46131
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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>5. What is the date by which the systemic changes will be completed?</p> <p>March 2, 2013</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G342		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/31/2013	
NAME OF PROVIDER OR SUPPLIER OCCAZIO INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1650 E JEFFERSON ST FRANKLIN, IN 46131			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W0153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview for 3 of 15 incident/investigative reports reviewed affecting clients C, D, F and H, the facility failed to report incidents of client to client abuse to the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 1/29/13 at 9:44 AM.</p> <p>1. On 1/6/13 at 5:30 PM, clients H and F were "flipping each other off." Client H yelled profanities at client F. Client F threw a cup of milk at client H. Client H ran over and held the cup to client F's neck causing a scratch on the right side of client F's neck. The incident was not reported to BDDS.</p> <p>2. On 12/17/12 at 3:25 PM, Client D threw a cup of juice at client H. Client D was prompted to leave the area. Client D went around the table and hit client C on the back. Client C had a red area on her</p>	W0153	<p>W 153 Staff Treatment of Clients</p> <p>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"> · All incidents of peer to peer aggression will be reported to BDDS and other officials in accordance with State law through established procedures. · All incidents of peer to peer aggression will be investigated by the Residential Coordinator. · The need to report and investigate all peer to peer incidents will be reviewed with the Residential Coordinator by 3-2-13. 	03/02/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G342	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/31/2013
NAME OF PROVIDER OR SUPPLIER OCCAIO INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1650 E JEFFERSON ST FRANKLIN, IN 46131		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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>left shoulder blade.</p> <p>3. On 12/8/12 at 3:45 PM, client F exited the medication room and "flipped [client H] off." Client F threw water on client H. Client H jumped up and went toward client F. Client H grabbed client F's shirt. The report indicated, "Blows were thrown by both clients." Client H had a scratch under his right eye and was bleeding. Client F had 2 small cuts on the inside of his bottom lip. The incident was not reported to BDDS.</p> <p>An interview with the Residential Coordinator (RC) was conducted on 1/30/13 at 10:27 AM. The RC indicated the facility was not reporting to BDDS peer to peer aggression unless there was significant injury until recently. The RC indicated the facility was following the BDDS guidelines.</p> <p>An interview with the Area Residential Coordinator (ARC) was conducted on 1/30/13 at 10:27 AM. The ARC indicated the facility was directed on 1/28/13 to report to BDDS all incidents of peer to peer aggression.</p> <p>9-3-2(a)</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. · All incidents of peer to peer aggression will be reported to BDDS and other officials in accordance with State law through established procedures. · All incidents of peer to peer aggression will be investigated by the Residential Coordinator. · The need to report and investigate all peer to peer incidents will be reviewed with the Residential Coordinator by 3-2-13. <p>1. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> · All incidents of peer to peer aggression will be reported to BDDS and other officials in accordance with State law through established procedures. 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G342	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/31/2013
NAME OF PROVIDER OR SUPPLIER OCCAZIO INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1650 E JEFFERSON ST FRANKLIN, IN 46131		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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"> · All incidents of peer to peer aggression will be investigated by the Residential Coordinator. · The need to report and investigate all peer to peer incidents will be reviewed with the Residential Coordinator by 3-2-13. <p>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · The RC will monitor on a regular basis daily when in the home. · The Program Specialist will monitor as she completes her audits. <p>1.What is the date by which the systemic changes will be completed?</p> <ul style="list-style-type: none"> · March 2, 2013 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G342		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/31/2013	
NAME OF PROVIDER OR SUPPLIER OCCAZIO INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1650 E JEFFERSON ST FRANKLIN, IN 46131			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W0249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>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, interview and record review for 1 of 4 clients in the sample (B), the facility failed to ensure client B had his walker and gait belt accessible to him at the day program per his risk plan for falls.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 1/30/13 from 10:12 AM to 11:34 AM. During the observation, client B was not at the home. Client B's walker and gait belt were in the living room at the group home.</p> <p>A review of client B's record was conducted on 1/30/13 at 10:38 AM. Client B's Risk Plan for Falls, dated 11/28/12, indicated, in part, "Staff should utilize [client B's] gait belt PRN (as needed), as he tolerates. Staff should assist [client B] with using his walker PRN, as he tolerates. His walker should only be used inside, on even surfaces."</p>	W0249	<p>W 249 Program Implementation</p> <p>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 an frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · Client B's fall risk plan will be reviewed with staff during their team meeting on 2-26-13. · The importance of ensuring that all adaptive equipment is taken to workshop on a daily basis will be reviewed with staff at their team meeting on 2-26-13. · Client B is on a program to teach him to utilize his gait belt 	03/02/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G342		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/31/2013	
NAME OF PROVIDER OR SUPPLIER OCCAZIO INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1650 E JEFFERSON ST FRANKLIN, IN 46131			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 interview was conducted with the Residential Coordinator (RC) on 1/30/13 at 10:31 AM. The RC indicated client B had a fall risk plan with a gait belt and walker to use as needed. The RC indicated client B refuses to use the gait belt and walker. The RC indicated there was a program plan to get client B to use the equipment. The RC indicated the gait belt and walker were not sent to the day program due to client B refusing to use the equipment.</p> <p>An interview with the nurse was conducted on 1/30/13 at 2:31 PM. The nurse indicated client B's risk plan should be implemented as written. The nurse indicated client B's walker and gait belt should be sent to the day program for client B to use.</p> <p>9-3-4(a)</p>		<p>and walker.</p> <ul style="list-style-type: none"> · Client B's walker and gait belt are going to workshop on a daily basis. <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 importance of ensuring that all adaptive equipment is taken to workshop on a daily basis will be reviewed with staff at their team meeting on 2-26-13. · The adaptive equipment needs of all of the residents will be reviewed with the staff at their team meeting on 2-26-13. · The risk plans of all of the residents will be reviewed with the staff at their team meeting on 2-26-13. <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: 15G342	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/31/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OCCAZIO INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1650 E JEFFERSON ST FRANKLIN, IN 46131
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 importance of ensuring that all adaptive equipment is taken to workshop on a daily basis will be reviewed with staff at their team meeting on 2-26-13. · The adaptive equipment needs of all of the residents will be reviewed with the staff at their team meeting on 2-26-13. · The risk plans of all of the residents will be reviewed with the staff at their team meeting on 2-26-13. <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · The RC will monitor on a daily basis when they are in the home. · The Program Specialist will monitor as they complete their audits. <p>5. What is the date by which the systemic changes will be completed?</p> <p>March 2, 2013</p>	