

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G322	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/03/2012
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NAME OF PROVIDER OR SUPPLIER OCCAZIO INC	STREET ADDRESS, CITY, STATE, ZIP CODE 568 YORKTOWN RD GREENWOOD, IN46142
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W0000	<p>Paper compliance was completed 1/3/12 for the Fundamental Certification and State Licensure survey completed 10/6/11.</p> <p>Facility Number: 000840 Provider Number: 15G322 AIMS Number: 100244010</p> <p>Surveyor: Steve Corya, Surveyor Supervisor</p> <p>Tags Corrected: W149, W156 Not Corrected: W198</p>	W0000		
W0198	<p>Clients who are admitted by the facility must be in need of and receiving active treatment services.</p> <p>Based on observation, record review and interview for 1 of 4 sampled clients (#4), the facility failed to ensure the client was in need of active treatment.</p> <p>Findings include:</p> <p>On 10/04/11 from 4:00 PM to 6:00 PM and 10/05/11 from 6:00 AM to 8:00 AM at the group home, client #4</p>	W0198	<p>1.What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · 450b submitted to BDDS on 10/26/2011 · LOC packet submitted to OMPP on 10/28/2011 · Letter outlining reasons for waiver services submitted on 11/14/11. · Email contact with Gary Antelept to follow-up in regard to process on 12/5/2011 and 12/12/2011. · Telephone contact with 	07/01/2012

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

TITLE

(X6) DATE

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

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	<p>independently interacted with staff and other clients. Client #4's communication skills were clear and she articulated her words in an understandable manner.</p> <p>On 10/04/11 from 5:00 PM to 6:00 PM client #4 independently directed her own leisure activities.</p> <p>During the morning meal, on 10/05/11 at 6:15 AM, client #4, without assistance from staff, served herself cold cereal and ate without redirection/training, and independently took her dishes to the kitchen once she was finished.</p> <p>On 10/05/11 at 6:45 AM client #4 was observed administering her own medications. Client #4 punched the medication out of the card into a cup, told the staff what medication it was, why she was taking it and what the side effects were for the medication.</p> <p>In an interview with client #4 on 10/04/11 at 10:00 AM she indicated she could read, write and has been taking dog grooming classes through assistance from Vocational Rehabilitation.</p> <p>On 10/04/11 at 11:00 AM client #4 was observed at the vocational day program. Client #4's supervisor indicated she was a good worker, able to get work, complete</p>		<p>Gary Anteleft to follow-up in regard to process on 1/4/2012.</p> <p>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · Clients' assessments reviewed in regard to active treatment needs. <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"> · Training with Residential Coordinator regarding assessment of client's active treatment needs. <p>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · Clients will be assessed annually in regard to active treatment needs. <p>1.What is the date by which the systemic changes will be completed?</p> <p>July 1, 2012</p>		

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	<p>tasks and put work in a completed area without supervision from staff. The supervisor stated client #4 "could work on several jobs, and did not require a lot of instructions on how to complete new jobs."</p> <p>On 10/04/11 at 5:00 PM, Direct Contact Professional (DCP) #9 stated, "[Client #4] can independently brush her teeth, toilet, eat and bathe." DSP #9 indicated client #4 can initiate her own leisure activities at the group home. DSP #9 indicated client #4 develops a monthly calendar of activities in the community she will participate in.</p> <p>Client #4's records were reviewed on 10/05/11 at 8:00 AM. The client's 12/09/10 ISP (Individual Support Plan) indicated the client's diagnosis included, but was not limited to, Mild Mental Retardation. The ISP indicated the client was ambulatory, followed directions, communicated wants/needs, was friendly and recognized dangers. The client's Comprehensive Functional Assessment (CFA), updated 07/22/11, indicated she was independent in hygiene tasks, "[Client #4] is independent with all aspects of showering, hand washing, toileting, applying deodorant, fixing hair, etc." The CFA indicated, "[Client #4] is independent with doing her work, and</p>			

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

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FORM APPROVED

OMB NO. 0938-0391

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	<p>with acquiring more work ... [client #4] is independent with all aspects of taking her medications."</p> <p>On 10/05/11 at 11:00 AM, Administrative Staff #1 stated the team "was not certain [client #4] needed active treatment, since she independently functioned in many areas."</p> <p>9-3-4(a)</p>				