

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G567		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/22/2012	
NAME OF PROVIDER OR SUPPLIER OCCAIO INC				STREET ADDRESS, CITY, STATE, ZIP CODE 11 GLORIA DR TRAFALGAR, IN 46181			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 a fundamental recertification and state licensure survey.</p> <p>Survey Dates: May 1, 3, 4, 7 and 22, 2012</p> <p>Facility Number: 001081 Provider Number: 15G567 Aim Number: 100239920</p> <p>Surveyor: Jo Anna Scott, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed on June 8, 2012 by Dotty Walton, 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: 15G567		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/22/2012	
NAME OF PROVIDER OR SUPPLIER OCCAIO INC				STREET ADDRESS, CITY, STATE, ZIP CODE 11 GLORIA DR TRAFALGAR, IN 46181			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W0126	<p>483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.</p> <p>Based on observation, record review and interview for 3 of 4 sample clients (clients #2, #3 and #4), the facility failed to use real money when training the money goals.</p> <p>Findings include:</p> <p>During the observation period on 5/3/12 from 4:40 PM to 6:25 PM, clients #2, #3 and #4 were observed sitting at the dining room table working on training goals and activities. Staff #5 was in the dining room with clients #2, #3 and #4. Staff #5 indicated they were working on training goals. Staff #5 had monopoly play money and was asking clients to identify different amounts of money.</p> <p>The record review for client #2 was conducted on 5/3/12 at 12:33 PM, the Individualized Support Plan (ISP) dated 3/9/12 had the money management goal as follows: Will be able to identify how much a quarter is worth.</p> <p>The record review for client #3 was conducted on 5/3/12 at 11:54 AM. The</p>	W0126	<p>1.What corrective action will be accomplished?</p> <ul style="list-style-type: none"> Real money is available for all training goals. <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"> All clients have the potential to be affected by this deficient practice. <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 all support staff regarding properly teaching clients about money. 	06/22/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G567		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/22/2012	
NAME OF PROVIDER OR SUPPLIER OCCAZIO INC				STREET ADDRESS, CITY, STATE, ZIP CODE 11 GLORIA DR TRAFALGAR, IN 46181			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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>ISP dated 2/4/12 indicated the money management goal was to hold a quarter in his hand.</p> <p>The record review for client #4 was conducted on 5/3/12 at 9:55 AM. The ISP dated 8/26/11 indicated the money management goal was learn to count (2) \$5.00 bills to equal \$10.00.</p> <p>Interview with staff #3 on 5/3/12 at 5:00 PM indicated they used the monopoly "play" money because the real money might get lost.</p> <p>9-3-2(a)</p>		<p>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <p>Residential Coordinator will observe programming with clients at least once monthly.</p> <p>1.What is the date by which the systemic changes will be completed?</p> <p>June 22, 2012</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G567		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/22/2012	
NAME OF PROVIDER OR SUPPLIER OCCAZIO INC				STREET ADDRESS, CITY, STATE, ZIP CODE 11 GLORIA DR TRAFALGAR, IN 46181			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W0242	<p>483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.</p> <p>Based on record review and interview for 4 of 4 sampled clients (clients #1, #2, #3 and #4), the facility failed to have personal hygiene goals and toothbrushing goals for clients who were not independent in these skills.</p> <p>Findings include:</p> <p>The record review for client #1 was conducted on 5/3/12 at 10:45 AM. The Individual Support Plan (ISP) for client #1 was dated 3/30/12. The formal training goals for client #1 were as follows:</p> <ol style="list-style-type: none"> 1. Independently state/point to the value of coin. 2. Will gather needed items to take meds (medication). 3. Will learn to take her time eating meals to decrease the chance of choking on her food while eating. 4. Will read flash cards and repeat 	W0242	<p>W242 Individual Program Plan</p> <p>The facility failed to have personal hygiene goals and toothbrushing goals for clients who were not independent in these skills.</p> <p>1.What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · Formal programming for Client 1, 2, 3 and 4 regarding bathing and toothbrushing skills. <p>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All client assessments and programming will be reviewed to</p>	06/22/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G567		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/22/2012	
NAME OF PROVIDER OR SUPPLIER OCCAZIO INC				STREET ADDRESS, CITY, STATE, ZIP CODE 11 GLORIA DR TRAFALGAR, IN 46181			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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>works to pronounce and enunciate words so she can communicate.</p> <p>There were no personal hygiene goals for bathing or toothbrushing.</p> <p>The record review for client #2 was conducted on 5/3/12 at 12:33 PM. The ISP dated 3/9/12 included the following formal training objectives:</p> <ol style="list-style-type: none"> 1. Independently identify objects (brush, book, animals, numbers, letters) to increase communication skills. 2. Will be able to identify how much a quarter is worth. 3. Will independently state reason for taking prescription medicine. 4. Will independently play games to increase his recreational leisure activities. 5. Independently complete steps of family style dining. <p>There were no personal hygiene goals for bathing or toothbrushing.</p> <p>The record review for client #3 was conducted on 5/3/12 at 11:54 AM. The ISP dated 2/4/12 included the following formal training goals:</p> <ol style="list-style-type: none"> 1. Independently go to the restroom and ensure his own privacy by shutting the door. 2. Independently return meds (medications) to storage. 		<p>ensure that clients are receiving training in accordance with skill level.</p> <p>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · Training with Residential Coordinator regarding addressing programmatically concerns of clients. <p>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · IDT will review skill assessments of clients at least annually and ensure that proper programmatic concerns are addressed. <p>1.What is the date by which the systemic changes will be completed?</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G567		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/22/2012	
NAME OF PROVIDER OR SUPPLIER OCCAZIO INC				STREET ADDRESS, CITY, STATE, ZIP CODE 11 GLORIA DR TRAFALGAR, IN 46181			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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. Learn to hold a quarter in his hand.</p> <p>4. Increase his skills in family style dining activities with his peers.</p> <p>5. Increase his communication skills by identifying objects.</p> <p>There were no personal hygiene goals for bathing or toothbrushing.</p> <p>The record review for client #4 was conducted on 5/3/12 at 9:55 AM. The ISP dated 8/26/11 included the following formal training objectives:</p> <ol style="list-style-type: none"> 1. Will independently participate in tossing a ball with staff/peers. 2. Increase his skills in repeating words in books, magazines and card games. 3. Independently exercise by walking for 20 minutes. 4. Learn to count two \$5.00 bills to equal \$10.00. 5. Will independently select bedtime medication from storage by recognizing color coding. <p>There were no personal hygiene goals for bathing or toothbrushing.</p> <p>Interview with staff #2, Home Manager (HM), on 5/3/12 at 1:40 PM indicated all the clients in the home needed assistance with bathing and toothbrushing. Staff #2, HM indicated she did not know why there were no bathing goals or toothbrushing goals.</p>		June 22, 2012				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G567	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/22/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OCCAZIO INC	STREET ADDRESS, CITY, STATE, ZIP CODE 11 GLORIA DR TRAFALGAR, IN 46181
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	9-3-4(a)			