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 01/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM OCCAZIO LLC	568 YORKTOWN RD GREENWOOD, IN 46142

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W 0000 Bldg. 00	This visit was for a fundamental recertification and state licensure survey. Dates of Survey: January 21, 22, 25, 26, 2016 Provider Number: 15G322 Aims Number: 100244010 Facility Number: 000840 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 2/1/16.	W 0000		
W 0125 Bldg. 00	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on observation, interview and record review for 4 of 4 sampled clients (#1, #2, #3, #4), the facility failed to ensure the clients had the right to due process in regard to door bells on the bathroom doors.	W 0125	**1.What corrective action will be accomplished?** · Human Rights Approval obtained for use of door bells on bathroom doors on 1/27/2016. **1.How will we identify other residents having the potential to be**	02/25/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Findings include: During the observation on 1/21/16 from 4:18p.m to 6:48p.m., at the group home, the doors to enter/exit the facility bathrooms had working bells hung on the top of the doors. The bells could be heard when the bathroom doors were opened and closed. Record review for client #1 was done on 1/25/16 at 2:20p.m. Client #1's 5/29/15 individual support plan (ISP) did not indicate/include the facility practice to have door bells placed on the facility bathroom doors. The ISP did not indicate client #1 was in need of this restriction. Record review for client #2 was done on 1/25/16 at 2:35p.m. Client #2's 2/2/15 ISP did not indicate/include the facility practice to have door bells placed on the facility bathroom doors. The ISP did not indicate client #2 was in need of this restriction. Record review for client #3 was done on 1/25/16 at 2:54p.m. Client #3's 5/29/15 ISP did not indicate/include the facility practice to have door bells placed on the facility bathroom doors. The ISP did not indicate client #3 was in need of this restriction.		**affected by the same deficient practice and what corrective action will be taken?** · Human Rights Approval obtained for all clients in regard to use of door bells on bathroom doors on 1/27/2016. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Training with Program Director (QIDP) and Program Coordinator regarding restrictive measures and process for obtaining approval. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · During monthly home observations and environmental checks, Program Director will monitor for any use of restrictive measures that have not been approved. **1.What is the date by which the systemic changes will be completed?** February 25, 2016	

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	Record review for client #4 was done on 1/25/16 at 1:35p.m. Client #4's 4/4/15 ISP did not indicate/include the facility practice to have door bells placed on the facility bathroom doors. Professional staff #1 was interviewed on 1/25/16 at 3:28p.m. Staff #1 indicated the door bells on the facility bathroom doors were due to client #4's flushing items behavior. Staff #1 indicated this restriction was not addressed in clients #1, #2, #3 and #4's ISPs. 9-3-2(a)			
W 0140 Bldg. 00	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview, the facility failed for 2 of 8 client finances reviewed (#4, #6) to maintain their financial system to ensure client funds entrusted to the facility had no missing funds. Findings include:	W 0140	**1.What corrective action will be accomplished?** · Client 4 and Client 6 had change from an outing that had not yet been returned to Program Coordinator. · Staff will be trained on 2/17/2016 on process of returning change/receipts following outings. **1.How will we identify other**	02/25/2016

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	The client financial record book and cash on hand (at the group home) entrusted to the facility were reviewed on 1/21/16 at 3:38p.m. The clients' individual petty cash form indicated: client #4 had a current balance of $41.56. Client #4's actual cash on hand was $41.06. Client #6 had a ledger balance of $35.51 and an actual cash on hand of $35.00. Interview on 1/21/16 at 3:38p.m. of staff #2 indicated the clients' funds entrusted to the facility and current available funds should match. Staff #2 indicated client transactions and receipts were monitored 2 to 3 times a week and she was not sure why there were missing funds. 9-3-2(a)		**residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All clients have the potential to be affected by this practice. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Protocol developed for transfer of money following outings. · Staff will be trained on 2/17/2016 regarding this protocol. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · Program Coordinator will check money to ledger balance 3x weekly and turn documentation into Program Director weekly. · Program Director will check money to ledge balance at least once monthly. **1.What is the date by which the systemic changes will be completed?** February 25, 2016	
W 0159 Bldg. 00	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by			

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	a qualified mental retardation professional. Based on record review and interview, the facility failed for 1 of 4 sampled clients (#1) to ensure each client's active treatment program were coordinated and monitored by the facility's qualified intellectual disabilities professional (QIDP), by the QIDP not ensuring a guardian's written consent for restrictive programs had been returned via the mail (#1). Findings include: The record of client #1 was reviewed on 1/25/16 at 2:20p.m. Client #1's 5/29/15 individual support plan (ISP) indicated client #1 had a guardian. The ISP indicated client #1 had a restrictive behavior support plan which included behavior medication. There was documentation the 5/15 ISP had been sent to the guardian. There was no documentation of guardian written informed consent for client #1's 5/29/15 ISP. Staff #1 was interviewed on 1/25/16 at 3:28p.m. Staff #1 indicated client #1's guardian had been sent a copy of her 5/29/15 ISP/BSP but had not returned a written consent for the programs. Staff #1 indicated there was no documentation the QIDP had followed up on obtaining the	W 0159	**W159 QIDP** The facility failed for 1 of 4 sampled clients (#1) to ensure each client's active treatment program were coordinated and monitored by the facility's QIDP, by the QIDP not ensuring a guardian's written consent for restrictive programs had returned via the mail. **1.What corrective action will be accomplished?** · ISP and Behavior Plan reviewed with guardian and signature obtained for plan. **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?** · QIDP will review all restrictive plans to ensure that guardian approval has been obtained. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · All correspondence with guardian for approval will be sent certified mail. · QIDP will track correspondence on a tracking log to ensure follow-up is completed and signatures are obtained. · **Area Director will review tracking log weekly to ensure that**	02/25/2016

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	guardian signature for the ISP/BSPs. Staff #1 indicated the QIDP was responsible for the coordination and monitoring of obtaining guardian written consent. 9-3-3(a)		**follow up is completed when approval needs to be obtained.** **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · Area Director will review tracking logs weekly. · **Area Director will review all paperwork following the ISP to ensure guardian participation has occurred. If guardian was unable to participate in person, Area Director will ensure that paperwork is sent immediately for approval of ISP and Behavior Plan.** **1.What is the date by which the systemic changes will be completed?** February 25, 2016	
W 0249 Bldg. 00	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. Based on observation, record review and interview, the facility failed for 1 of 4 sampled clients (#4) to ensure the client's training programs were implemented when opportunities were present.	W 0249	**W249 Program Implementation** The facility failed for 1 of 4 sampled clients (#4) to ensure the client's training programs were implemented when opportunities were present.	02/25/2016

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	Findings include: An observation was done on 1/25/16 from 12:02p.m. to 1:05p.m. at the facility operated day program. From 12:02p.m. to 1:05p.m., client #4 was in her wheelchair in the activity room area. Client #4 self propelled herself around the room and did not participate in any of the day program activities. Staff did not prompt client #4 to participate in any activity. Staff did assist client #4 in the bathroom at 12:29p.m. There was a movie group, 2 groups of games and a group doing drawings. Staff #3 was interviewed on 1/25/16 at 12:24p.m. at the day program. Staff #3 indicated client #4 likes to play bingo, will sit in on card games and liked to color and draw. Record review for client #4 was done on 1/25/16 at 1:35p.m. Client #4 had an individual support plan (ISP) dated 4/4/15. The ISP indicated the following: client #4 requires prompts to initiate most tasks and then needs frequent physical assist with task; at day service participate in an exercise program, participate in a planned activity, given opportunity to participate in a variety of activities daily. The ISP indicated client #4 had training programs to point to pictures in a book or magazine and ask her what items were in		**1.What corrective action will be accomplished?** · Training with group home staff regarding Client 4's plan and in engaging Client 4 in active treatment. · Training with day program staff regarding Client 4's plan and in engaging Client 4 in active treatment. **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?** · All clients have the potential to be affected by this practice. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · **Program Coordinator will document observation of Client 4's participation in programming at the group home and day program 3x weekly.** · **Program Coordinator will forward documentation of observation to Program Director weekly.** **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · **QIDP will review documentation of observations weekly.**	

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	the pictures, count change, increase communication with sign language and answer questions. The ISP indicated client #4 enjoyed music and dancing. Staff #1 was interviewed on 1/25/16 at 3:28p.m. Staff #1 indicated facility staff should have been involved with providing client #4 with activity choices throughout her time at the day service program. 9-3-4(a)		· **QIDP will forward documentation of observations to Area Director weekly for review.** **1.What is the date by which the systemic changes will be completed?** February 25, 2016	
W 0263 Bldg. 00	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. Based on record review and interview, the facility's human rights committee (HRC) failed for 1 of 1 sampled client (#1) with a guardian, to ensure the facility had received written informed consent from the guardian, in regards to client #1's restrictive program which included behavior medication, prior to HRC approval.	W 0263	**W263 Program Monitoring and Change** The facility's human rights committee (HRC) failed for 1 of 1 sampled client (#1) with a guardian, to ensure the facility had received written informed consent from the guardian, in regard to client #1's restrictive program which included behavior medication, prior to HRC approval.	02/25/2016

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	Findings include: Record review for client #1 was done on 1/25/16 at 2:20p.m. Client #1's 5/29/15 individual support plan (ISP) indicated client #1 had a restrictive behavior plan that included the use of behavior medication for depression. The ISP indicated client #1 had a guardian. The facility's human rights committee (HRC) had approved the ISP on 7/27/15. There was no documentation of written consent by client #1's legal guardian for the 5/29/15 ISP. Staff #1 was interviewed on 1/25/16 at 3:28p.m. Staff #1 indicated the facility did not have written informed consent from client #1's guardian in regards to client #1's 5/29/15 restrictive behavior program. Staff #1 indicated the facility's HRC had approved client #1's restrictive behavior program without written informed consent from client #1's guardian. 9-3-4(a)		**1.What corrective action will be accomplished?** · Develop protocol for Human Rights Committee in regard to approval of plans. **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 client's plans will be reviewed to ensure that the plans have guardian consent prior to HRC approval. **3 What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Training with HRC members on protocol for approval of plans. **4 How will the corrective action be monitored to ensure the deficient practice will not recur?** · Area Director will review plans prior to HRC meeting to ensure that guardian approval has been obtained. **5 What is the date by which the systemic changes will be completed?** February 25, 2016	

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W 0264 Bldg. 00	483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. Based on observation, record review and interview, the facility's Human Rights Committee (HRC) failed for 8 of 8 clients (#1, #2, #3, #4, #5, #6, #7, #8) residing in the facility to review restrictive interventions: the facility practice of the use of bathroom door bells on the facility bathroom entrance/exit doors. Findings include: During the observation on 1/21/16 from 4:18p.m to 6:48p.m., at the group home, the doors to enter/exit the facility bathrooms had working bells hung on the top of the doors. The bells could be heard when the bathroom doors were opened and closed. Record review of the facility's HRC reviews from 1/1/15 to 1/21/16 was done on 1/25/16 at 3:00p.m. There was no documentation the HRC had reviewed the facility's restrictive practice of	W 0264	**W264 Program Monitoring & Change** The facility's HRC failed for 8 of 8 clients residing in the facility to review restrictive interventions: the facility practice of the use of bathroom door bells on the facility bathroom entrance/exit doors. **1.What corrective action will be accomplished?** · Human Rights Approval obtained for use of door bells on bathroom doors on 1/27/2016 for all 8 clients. **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?** · All clients were affected by the practice. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**	02/25/2016

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	entrance/exit bathroom door bells for clients #1, #2, #3, #4, #5, #6, #7 and #8. Interview of staff #1 on 1/25/16 at 3:28p.m. indicated they could not find documentation the facility restriction of the use of bathroom entry/exit door bells had been presented to and reviewed by the facility's HRC during the past year. 9-3-4(a)		· Training with Program Director (QIDP) and Program Coordinator regarding restrictive measures and process for obtaining approval. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · During monthly home observations and environmental checks, Program Director will monitor for any use of restrictive measures that have not been approved. **1.What is the date by which the systemic changes will be completed?** February 25, 2016	
W 0289 Bldg. 00	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. Based on observation, record review and interview, the facility failed for 1 of 4 sampled clients (#4) with a restrictive behavior management plan, to ensure that all interventions (door bells on bathroom doors) to manage client #4's behaviors were included in the client's individual support plan (ISP).	W 0289	**W289 Management of inappropriate client behavior** The facility failed for 1 of 4 sampled clients (#4) with a restrictive behavior management plan, to ensure that all interventions (door bells on bathroom doors) to manage client 4's behaviors were included in the client's individual support plan.	02/25/2016

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	Findings include: During the observation on 1/21/16 from 4:18p.m to 6:48p.m., at the group home, the doors to enter/exit the facility bathrooms had working bells hung on the top of the doors. The bells could be heard when the bathroom doors were opened and closed. Review of the record of client #4 was done on 1/25/16 at 1:35p.m. Client #4's 4/4/15 ISP indicated client #4 had flushing items identified as a behavior in her plan. Client #4's ISP did not address the facility's use of bathroom door bells for her identified behavior of flushing items in the toilet. Interview of staff #1 on 1/25/16 at 3:28p.m., indicated the facility's bathroom door bells were for client #4's identified behavior of flushing items in the toilet. Staff #1 indicated client #4's program intervention (bathroom door bells) had not been incorporated into a training program. 9-3-5(a)		**1.What corrective action will be accomplished?** · Client 4's behavior plan updated to reflect restrictions. **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?** · QIDP will review all plans to ensure appropriate restrictive interventions are addressed. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Training with QIDP on ensuring necessary interventions for behavior are included in behavior plan. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · During monthly home observations and environmental checks, Program Director will monitor for any use of restrictive measures that have not been included in behavior plan. **1.What is the date by which the systemic changes will be completed?** February 25, 2016	

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