

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 04/26/2022
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 568 YORKTOWN RD GREENWOOD, IN 46142		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 a Post Certification Revisit (PCR) to the PCR completed on 1/10/22 to the pre-determined full recertification and state licensure survey completed on 10/29/21.</p> <p>Survey Dates: April 25 and 26, 2022</p> <p>Facility Number: 000840 Provider Number: 15G322 AIM Number: 100244010</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review of this report completed by #15068 on 5/5/22.</p>	W 0000		
W 0227 Bldg. 00	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on observation, interview and record review for 1 of 3 clients in the sample (#3), the facility failed to ensure client #3 had a plan to address her refusals to take Miralax for constipation.</p> <p>Findings include:</p> <p>On 4/25/22 from 2:59 PM to 4:29 PM, an observation was conducted at the group home. On 4/25/22 at 3:18 PM, client #3 refused to take her medications from the Program Supervisor (PS). On 4/25/22 at 4:04 PM, client #3 asked staff #3 to administer her medications. When</p>	W 0227	<p>W227 Individual Program Plan The facility failed to ensure Client 3 had a plan to address her refusals to take Miralax for Constipation.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> Client 3 had an appointment with her PCP on 4/28/2022 and communicated to her PCP that she did not like taking the Miralax. PCP changed the Miralax to Amitiza. 	05/26/2022

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: 15G322	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 04/26/2022
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 568 YORKTOWN RD GREENWOOD, IN 46142		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 #3 got out Miralax (constipation), client #3 refused to take the medication. Client #3 indicated she took the medication in the morning and did not want to take it again.</p> <p>On 4/26/22 at 11:17 AM, a review of a 4/15/22 Bureau of Developmental Disabilities Services incident report indicated, "[Client #3] woke up complaining of severe stomach pain. [Staff #1] contacted the [Program Supervisor]. Direction given to take [client #3] to the ER (emergency room) for evaluation. Staff took [client #3] to [name of ER]. [Client #3] did not present with a fever or any out of normal vitals but did continue to say she has pain in her stomach. A CT (computerized tomography) w/ (with) contrast was completed and found that [client #3] was constipated. [Client #3] currently has a order for Glycolax powder on a daily basis but [client #3] will often refuse this med. The attending physician counseled with [client #3] on the importance of her taking her meds as ordered. [Client #3] was released with orders to follow up with PCP (primary care physician) if necessary. [Client #3] returned home to rest... [Client #3] will take her medication as ordered to that should help prevent a reoccurrence of this issue."</p> <p>On 4/26/22 at 2:44 PM, a focused review of client #3's record was conducted and indicated the following:</p> <p>-Client #3's February 2022 Medication Administration Record (MAR) indicated she was prescribed Miralax for constipation three times a day. The MAR indicated she refused Miralax at least one time on the following dates: 2/1 to 2/8, 2/10, 2/12, 2/14 to 2/15, 2/18 to 2/20, and 2/22 to 2/28.</p>		<ul style="list-style-type: none"> Since beginning the medication, Client 3 has had only one refusal of the medication. <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. <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"> Retraining with support staff on reporting and documenting missed medications. <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> Program Supervisor will review MARs weekly to ensure that medications are being passed according to the order. RN will review MARs monthly to ensure that medications are being passed according to the order. <p>5. 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: 15G322	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 04/26/2022
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 568 YORKTOWN RD GREENWOOD, IN 46142		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 #3's March 2022 MAR indicated she refused Miralax at least one time on the following dates: 3/1, 3/3 to 3/5, 3/7 to 3/10, 3/13 to 3/18, and 3/20 to 3/31.</p> <p>-Client #3's April 2022 MAR indicated she refused Miralax at least one time on the following dates: 4/1 to 4/13 and 4/15 to 4/26.</p> <p>Client #3's 7/14/21 Individual Support Plan and 8/5/21 Risk Assessment Detail did not address her refusals to take her Miralax.</p> <p>On 4/26/22 at 2:43 PM, an email from the Program Director indicated, "I am reaching out to her parents/guardians due to her continued refusals as well as she is now scheduled with her PCP for this Thursday @ (at) 1:15pm to discuss options to this issue."</p> <p>On 4/26/22 at 11:37 AM, the Program Director (PD) stated "don't think she has been refusing." The PD indicated she was aware of past issues with client #3 refusing to take her Miralax but she did not put a plan in place. The PD stated she informed the staff "to counsel with her." The PD stated there was "no plan to address."</p> <p>On 4/26/22 at 2:21 PM, the Qualified Intellectual Disabilities Professional (QIDP) stated "she has a definite tendency to refuse the constipation medication." The QIDP indicated client #3's belly would swell up and she would be uncomfortable. The QIDP stated she "thought she had a plan. Should have one, absolutely." The QIDP indicated it was an on-going issue. The QIDP indicated client #3's interdisciplinary team needed to convene to discuss what to do when she refused to take her medication.</p>		May 26, 2022.	

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 04/26/2022
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 568 YORKTOWN RD GREENWOOD, IN 46142		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 0336 Bldg. 00	<p>On 4/26/22 at 2:34 PM, the Behavior Clinician (BC) stated "I don't think she has a plan in place for it (refusals to take her constipation medication)." The BC stated she had "been monitoring it." She spoke to client #3 once about her refusals and she told the BC the medication did not make her feel good. The BC stated "she'll take it when she realizes she doesn't feel good." The BC indicated client #3 would not take the medication unless she was in pain. The BC indicated she did not know the frequency of client #3's refusals to take the medication. The BC stated she "heard about it a few months ago. Haven't followed up to see the frequency (of refusals)." When asked if client #3 needed a plan to address her refusals to take her constipation medication, "I suppose so."</p> <p>9-3-4(a)</p> <p>483.460(c)(3)(iii) NURSING SERVICES</p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. Based on record review and interview for 2 of 3 clients in the sample (#2 and #3), the facility failed to ensure the clients had quarterly nursing reviews.</p> <p>Findings include:</p> <p>1) On 4/26/22 at 3:11 PM, a focused review of client #2's record was conducted. Client #2's record indicated she had a nursing quarterly on 9/30/20 (annual physical), 3/17/21 and 6/17/21. There was no documentation of a nursing quarterly being conducted since 6/17/21.</p>	W 0336	<p>W331 Nursing Services The facility failed to ensure that client 2 and 3 had quarterly nursing reviews.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> Client 3 had her quarterly physical appointment on 5/12/2022. Client 2 had her quarterly physical appointment on 5/12/2022. 	05/26/2022

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 04/26/2022
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 568 YORKTOWN RD GREENWOOD, IN 46142		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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>2) On 4/26/22 at 3:12 PM, a focused review of client #3's record was conducted. Client #3's record indicated she had a nursing quarterly on 4/13/21 (annual physical) and 7/13/21. There was no documentation the nurse conducted a nursing quarterly since 7/13/21.</p> <p>On 4/26/22 at 3:14 PM, the Area Director indicated the facility should have quarterly nursing reviews for each client.</p> <p>This deficiency was cited on 1/10/22. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(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. <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"> · Retraining with Program Supervisor on regulated appointments. · Retraining with Program Supervisor on appointment tracking form. · Retraining with Program Supervisor on appointment expectations and protocols. <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · IDT will conduct monthly staffings to address each client's appointment status and to ensure that appointments have been completed in a timely manner. · RN will conduct quarterly reviews of medical files for each client in the home. · RN will forward quarterly reviews of medical files to Area 	

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

PRINTED: 06/07/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G322	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 04/26/2022
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 568 YORKTOWN RD GREENWOOD, IN 46142		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 9999 Bldg. 00		W 9999	<p>Director upon completion.</p> <p>5. What is the date by which the systemic changes will be completed? May 26, 2022.</p> <p>No citation noted.</p>	05/26/2022