STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G322	A. BUILDING 00 B. WING	08/23/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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	This visit was for the investigation of complaint #IN00411717. Complaint #IN00411717: No deficiencies related to the allegation(s) were cited. Unrelated deficiencies cited. Dates of Survey: 8/21/23, 8/22/23, and 8/23/23 Facility Number: 000840 Provider Number: 15G322 AIMS Number: 100244010 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 9/7/23.	W 0000		
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 additional client (client G), the facility failed to conduct an investigation regarding an incident of client G's attempted self-harm. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed on 8/21/23 at 12:43 PM. The review indicated the following: - BDDS report dated 7/11/23 indicated, "During the evening of 7.11.23 [client G] came to staff to	W 0154	**W154 Staff Treatment of Clients** The facility failed to conduct an investigation regarding and incident of Client G's attempted self-harm. **1. What corrective action will be accomplished?** · Investigation completed regarding Client G's attempted self-harm.	09/23/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tracy Price	Area Director	09/26/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G322	A. BUILDING 00 B. WING	08/23/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	report she had taken some Tylenol (over the counter pain reliever), a few of them but then she said she took a handful. [Client G] did not exhibit (sic) of medical decline or any affect (sic) of this. [PS (Program Supervisor)] called [RN (Registered Nurse)] who advised to count the number of pills in the bottle. It is a 100 pill bottle that now had 48 pills in the container. Due to [client G's] history of not reporting accurate information it was decided she be taken to the ER (Emergency Room) for further evaluation. Once at [hospital ER] (sic). After medical assessment and referral for psych evaluation it was determined [client G] would be admitted for stress and anxiety. At this time we await further communication regarding her stay. All calls made per protocol." Investigations were reviewed on 8/21/23 at 1:43 PM. An investigation for the BDDS report dated 7/11/23 was not available. AD (Area Director) was interviewed on 8/21/23 at 4:56 PM. AD indicated an investigation was not completed for the incident on 7/11/23 in which client G reported having taken a handful of over the counter medication. QIDP (Qualified Intellectual Disability Professional) was interviewed on 8/22/23 at 11:06 AM. QIDP indicated client G was not on a self medication administration program. QIDP indicated client G needed monitoring to take medications. QIDP indicated all medications should be kept locked. QIDP indicated uncertainty of an investigation being completed. QIDP indicated the IDT (Interdisciplinary Team) did not meet to discuss client G reportedly taking a handful of over the counter medication. QIDP indicated there was not a plan in place to prevent client G from bringing over the counter		**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?** · Incidents reviewed to ensure investigations are completed that meet investigation criteria. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Quality Improvement will review incidents and inform Area Director of incidents that require investigations. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · Quality Improvement will monitor to ensure that incidents have been investigated. · Quality Improvement will send email notifications to Regional Director and Area Director as reminders of incidents that have outstanding investigations. **5. What is the date by which the systemic changes will be completed?** September 23, 2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G322	A. BUILDING 00 B. WING	08/23/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	medications back, given to her by friends, after a leave of absence from the group home. QIDP indicated the ISP (Individual Support Plan) and/or the BSP (Behavioral Support Plan) were not updated following client G allegedly taking a handful of over the counter medication. Nurse #1 was interviewed on 8/22/23 at 11:10 AM. Nurse #1 indicated all medication should have a standing order from the physician and be kept locked in the group home. Nurse #1 indicated individuals ask for over the counter medications as needed. Nurse #1 indicated when individuals are on leave from the group home, the medications are given to the caregiver with written instructions regarding administration. Nurse #1 indicated when the individuals return all medications are checked in by DSPs (Direct Support Professionals). Nurse #2 was interviewed on 8/22/23 at 11:50 AM. Nurse #2 indicated all over the counter medications required a physician order and should be kept locked. Nurse #2 indicated staff called her after client G reported taking a handful of over the counter medication. Nurse #2 indicated the over the counter medication was purchased by client G during a leave of absence from the group home. Nurse #2 indicated client G was taken to the ER, lab work was completed and there were no health outcomes due to taking a handful of over the counter medication. AD (Area Director) was interviewed on 8/22/23 at 11:57 AM. AD indicated it was her responsibility to conduct investigations for all abuse, neglect, exploitation, peer to peer aggression and falls within 5 working days of the incident. 9-3-2(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G322	A. BUILDING 00 B. WING	08/23/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 1 additional client (client G), the facility failed to develop corrective action to prevent client G from bringing over the counter medications back from a community visit. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed on 8/21/23 at 12:43 PM. The review indicated the following: - BDDS report dated 7/11/23 indicated, "During the evening of 7.11.23 [client G] came to staff to report she had taken some Tylenol (over the counter pain reliever), a few of them but then she said she took a handful. [Client G] did not exhibit (sic) of medical decline or any affect (sic) of this. [PS (Program Supervisor)] called [RN (Registered Nurse)] who advised to count the number of pills in the bottle. It is a 100 pill bottle that now had 48 pills in the container. Due to [client G's] history of not reporting accurate information it was decided she be taken to the ER (Emergency Room) for further evaluation. Once at [hospital ER] (sic). After medical assessment and referral for psych evaluation it was determined [client G] would be admitted for stress and anxiety. At this time we await further communication regarding her stay. All calls made per protocol." QIDP (Qualified Intellectual Disability Professional) was interviewed on 8/22/23 at 11:06 AM. QIDP indicated client G was not on a self medication administration program. QIDP	W 0157	**W157 Staff Treatment of Clients** The facility failed to develop corrective action to prevent Client G from bringing over the counter medications back from a community visit. **1. What corrective action will be accomplished?** · Corrective action completed regarding Client G bringing OTC meds into the house following community visits. **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?** · Incidents reviewed to ensure corrective actions are completed following investigations of incident. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Quality Improvement will review incidents to ensure that corrective actions are in place following an investigation.	09/23/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G322	A. BUILDING 00 B. WING	08/23/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	indicated client G needed monitoring to take medications. QIDP indicated all medications should be kept locked. QIDP indicated uncertainty of an investigation being completed. QIDP indicated the IDT (Interdisciplinary Team) did not meet to discuss client G reportedly taken a handful of over the counter medication. QIDP indicated there was not a plan in place to prevent client G from bringing over the counter medications back from leave of absence from the group home. QIDP indicated the ISP (Individual Support Plan) and/or the BSP (Behavioral Support Plan) were not updated following client G allegedly taking a handful of over the counter medication. 9-3-2(a)		**4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · Quality Improvement will monitor to ensure that corrective actions are in place. **5. What is the date by which the systemic changes will be completed?** September 23, 2023	
W 9999 Bldg. 00	State Findings: The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met. 460 IC 9-3-2(c)(3) Resident protections Authority: IC 12-28-5-19 Affected: IC 4-21.5;IC 5-2-55; IC 12-28-5-12; IC 22-12 (c) The residential provider shall demonstrate that its employment practices assure that no staff person would be employed where there is: (3) conviction of a crime substantially related to a dependent population or any violent crime. The provider shall obtain, as a minimum, a bureau of motor vehicles record, a criminal history check as authorized in IC 5-2-5-5, and three (3) references.	W 9999	**W9999 Final Observations** The facility failed to ensure reference checks were completed for 2 staff members. **1. What corrective action will be accomplished?** · Reference checks for the two staff members will be completed by Office Coordinator. **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 residents have the	09/23/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G322	A. BUILDING 00 B. WING	08/23/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Mere verification of employment dates by previous employers shall not constitute a reference in compliance with this section. This state rule is not met as evidenced by: Based on record review and interview for 2 of 3 employee files reviewed (#1 and #2), the facility failed to ensure reference checks were completed for 2 staff members working in the home with clients A, B, C, D, E, F, G and H. Findings include: 1. Staff #1's employee record was reviewed on 8/21/23 at 2:41 PM. Staff #1's record did not indicate documentation of reference checks. 2. Staff #2's employee record was reviewed on 8/21/23 at 2:41 PM. Staff #2's record did not indicate documentation of reference checks. Office Coordinator was interviewed on 8/21/23 at 2:41 PM. Office Coordinator indicated staff #1 and staff #2 had 3 references. Office Coordinator indicated the reference sheet listed 3 names and numbers without comments indicating the references were checked. AD (Area Director) was interviewed on 8/22/23 at 11:56 AM. AD indicated reference checks are completed by the Office Coordinator. AD indicated the Office Coordinator should confirm references. 9-3-2(c)(3)		potential to be affected by the same deficient 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:** · Retraining with Office Coordinator on ensuring that reference checks are completed. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · Area Director will review all new employee files upon completion of new employee orientation to ensure that all components are completed. · Office Coordinator supplied with checklist for all new employee files. **1.What is the date by which the systemic changes will be completed?** September 23, 2023	