	T OF HEALTH AND HU R MEDICARE & MEDIC					FORM APPROVED OMB NO. 0938-039		
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	INSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15G353	A. BUILDING <u>00</u> B. WING		00	COMPLETED 03/21/2023		
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD ARKWAY DR	•		
REM OC	CAZIO LLC			ANDER	SON, IN 46012			
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	PF	ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
W 0000 Bldg. 00	0 This visit was for the investigation of complaints #IN00401300 and #IN00401402.		W 00	00				
	-	01300: Substantiated, Federal ies related to the allegation(s) 4 and W159.						
	Complaint #IN00401402: Substantiated, Federal and State deficiencies related to the allegation(s) were cited at: W249 and W287.							
	Dates of Survey: N 2023.	1arch 14, 15, 16, 17, and 21,						
	Facility Number: 0 Provider Number: AIMS Number: 10	15G353						
	These deficiencies accordance with 46	also reflect state findings in 50 IAC 9.						
	Quality Review of on 4/6/23.	this report completed by #27547						
W 0104	483.410(a)(1) GOVERNING BC	DY						
Bldg. 00	policy, budget, ar the facility. Based on record re sampled clients (B) exercise general po direction over the f	bdy must exercise general ad operating direction over view and interview for 1 of 3), the governing body failed to blicy, budget and operating facility to ensure oversight of	W 010	04	W104 – Governing Body the governing body failed to exercise general policy, budge and operating direction over th	ne	04/21/202	
	client B's social sec Findings include:	curity deficities.			facility to ensure oversight of of B's social security benefits.1. What corrective action will be accomplished?	, nent		

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

 Rachel Downing
 Area Director
 04/22/2023

 Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclos
 USA

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.

PRINTED:

05/08/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	R MEDICARE & MEDIC NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00		PLETED		
		15G353	B. WING	<u></u>	03/21/2023			
			STREE	ET ADDRESS, CITY, STATE, ZIP CO	D			
AME OF 1	PROVIDER OR SUPPLIEI	2		PARKWAY DR	-			
REM OC	CAZIO LLC		AND					
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)		
REFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP		COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	Horright	DATE		
	The facility's BDD	S (Bureau of Developmental		Program Director a	nd Area			
	Disabilities Service	es) reports and investigations		Director will do an audit	of all			
	were reviewed on 3	3/14/23 at 11:45 AM and		individuals' benefits. The	ey will work			
	indicated the follow	ving:		with individual funds spe	cialists to			
				ensure they have neces				
	A BDDS report dat	ed 2/7/23 indicated, "[LTO		information/documents t	-			
	-	dsman) #1], called [SC (Service		benefits are active.				
		nd explained that she (LTO #1)		Program Director a	nd Area			
		client B's relative]. [Client B's		Director will have regula				
	-	[client B] has been with		meetings with individual	-			
	-	L (Supervised Group Living)		specialist/intake coordin				
	for 3 years and [name of service provider] prior to that. She states that the family has asked Indiana Mentor about Social Security for [client B]. She states that she gets the 'run around' and that the person who filed for it (from Indiana Mentor) is no			ensure new admissions				
				benefits in place rep pay				
				paperwork submitted pro	-			
				etc.	, sinpuly,			
				• Will ensure that Cli	ent Bs			
	-	re, and took the files with her.		social security benefits h				
		ks at [name of store] 2 days a		reinstated.				
		es that money either She		2. How will we identif	fy other			
		is clothes 'always seem to		residents having the po	-			
		He lives with 7 other men She		to be affected by the sa				
		ney (client B's family) have		deficient practice and v				
		tor to get in touch with his		corrective action will be				
		ice coordinator from BDDS)		· All residents have t				
		help them with this. The						
	-	o make sure things are right and		potential to be affected b	y uie			
	-	not stealing [client B's]		same deficient practice. • Program Director a	nd Area			
	money".	not stearing [chefit D 8]		Director will do an audit				
	money							
	TMNDEIL (The Me	ntor Network Denost Form for		individuals' benefits. The	-			
		entor Network Report Form for $\frac{1}{2}$		with individual funds spe				
	-	on) dated 3/9/23 indicated the		ensure they have neces information/documents t	-			
	following:				o ensure			
	" Deal	formation on the alignst the		benefits are active.	un al 10 una -			
	-	formation on the client, the		Program Director a				
	placement, the staff			Director will have regula				
		ividual who resides in an		meetings with individual				
		up home located at		specialist/intake coordin				
		ne] in [city, state]. [Client B]		ensure new admissions				
		me of group home] in October		benefits in place rep pay				
	of 2019. Prior to th	at he has resided in [name of		paperwork submitted pro	omptly,			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

FG7911 Facility ID: 000869

If continuation sheet

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PRINTED: 05/08/2023 FORM APPROVED

OMB NO. 0938-039

	T OF HEALTH AND HU R MEDICARE & MEDIO				FORM AF OMB NO.	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	JLTIPLE CONSTRUCTION (X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		15G353	B. WING		03/21/2023	5
					00/2 // 2020	
NAME OF 1	PROVIDER OR SUPPLIE	R		T ADDRESS, CITY, STATE, ZIP COD		
				PARKWAY DR		
REM OC	CAZIO LLC		AND	ERSON, IN 46012		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DROWIDEDIC DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		IPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		DATE
		B's] grandmother was his		etc.		
	guardian until he ti			• Will ensure that Client E	le l	
	guardian antir ne t			social security benefits have		
	Factual Findings			reinstated.	Deell	
	Review of Docume	antation		Teinstated.		
	Finances:	at Diller manager (0 \A//		
	-	nt B] has numerous transactions		3. What measures will be	-	
	for talk to text mes	-		into place or what systemic		
	-	hased pops for his housemates-		changes will be made to		
	[client B] signed of	ff as him doing		ensure that the deficient		
	this.			practice does not recur:		
	· ·	rchases made at [name of		 Program Director and A 	rea	
		of department store] and [name		Director will do an audit of al		
	of department store	e].		individuals' benefits. They wi	ll work	
	December 2022 with	thdrew \$20 cash to take home		with individual funds speciali	sts to	
	with him, purchase	es at [name of department store],		ensure they have necessary		
	[name of restauran	t], gas station.		information/documents to en	sure	
	January 2023 purch	hases [name of movie theatre]		benefits are active.		
	movies.			Program Director and A	rea	
	February 2023 pur	chases made eating out, [name		Director will have regular follo		
	of department store	e]- multiple purchases, Gas		meetings with individual fund	-	
	-	department store], [name of		specialist/intake coordinators		
	-	partment store], and [name of		ensure new admissions have		
	department store]			benefits in place rep payees		
	1 1			paperwork submitted prompt		
	[IC (Intake Coordi	nator) #1] (per email and		etc.	<i>.</i> ,	
	conversation 2/28/			4. How will the corrective		
		d to look into his case, during		action be monitored to ensu		
	· · · ·	ial Security) shut down, I (IC #1)		the deficient practice will no		
		d was told that I could not		recur?		
		l account to submit		Program Director and A	rea	
		that is not allowed, if you are		Director will do an audit of all		
		Institutional Representative		individuals' benefits. They wi		
	Payee Application.	-		with individual funds specialis		
		old that he (IC #1) could not				
	· · · ·			ensure they have necessary		
		ail, as there were only a		information/documents to en	sure	
		each office, and they were only		benefits are active.		
		o off in their mail box at that time.		Program Director and A		
		did mail an application to the		Director will have regular follo	-	
	[[name of city] SS of	office though, as he		meetings with individual fund	s	

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Event ID: FG7911 Facility ID: 000869

If continuation sheet

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G353	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 03/21/2023	
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP COD PARKWAY DR		
REM OC	CAZIO LLC			RSON, IN 46012		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	N .	
	remembers stressin #1's) name, and if application. (email) He (IC #1) another application in May of 2022. Stated if the indivi- wouldn't have bee unless they were s then only if he ma might received a p security. [SSC (Social Secu Stated she has bee months. Stated she has bee 1/17/2023 Stated she talked t Stated she talked t Stated she submitt become Represent on January 20th, 2 Stated she was tol- anywhere from 2-0 looked at. Stated she was infl other paperwork a an disabled adult of draw social securi- and apply for SSD Insurance). Stated she has an a 9am to talk to soci [IFS (Individual F Stated at the time MENTOR service	ng about including a - in his (IC that was allowed on an) may have also submitted n after his local SS reopened idual was working he (client B) n entitled to social security ending in his paystubs and de below a certain amount he partial payment from social urity Coordinator) #1] n in this position for about 3 n working on [client B] since o Social Security yesterday. ed an application for us to ative Payee for him 2023. d yesterday that it could take 6 weeks to get formed also that he is missing s well and needs child application in order to ty off of his parents of (Social Security Disability hitting the application online. appointment set for 3/16/2023 at ial security. inance Specialist) #1] [client B] moved into Indiana		specialist/intake coordinato ensure new admissions has benefits in place rep payee paperwork submitted prom etc. • Will ensure that Client social security benefits hav reinstated. 5. What is the date by w the systemic changes will completed? 4-21-2023	rs to ve ship ptly, Bs e been /hich	

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2)	MULTIPLE CO	(X3) DA	OMB NO. 0938-03 (X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER	r í	BUILDING	00	CO	COMPLETED	
		15G353	B. WING			/21/2023		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD			COD		
					ARKWAY DR			
REM OC	M OCCAZIO LLC			ANDER	SON, IN 46012			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)	
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TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		1's) knowledge he was working						
	since he has been in							
	Stated he doesn't pa							
		eceived pay stubs for him she						
	would have sent the							
	U U	RFMS (Resident Fund						
	Ũ	ce), she only shows his d and those stopped in						
	August (2022), whe							
	e ().	ble for back pay, his prior pay						
	stubs or wage histor							
	to be turned in to so	-						
	Conclusion of Facts	5						
	Evidence supports	hat there has been a						
	breakdown in comr	nunication regarding						
	securing benefits for	r [client B] since his						
		ded. This writer was unable						
		ong [client B] had been						
	working.							
		here has been recent contact						
	with the Social Sec	-						
		egards applying for Indiana						
	MENTOR to be rep							
		ll him applying for social Ie, it was learned that						
	-	al forms that would need to be						
	filled out and sent i							
	A review of TMNR	FII dated 3/9/23 indicated						
	client B moved into	the group home in October						
		ndicated the administration						
	attempted to contac	t the Social Security						
		ing the Covid Social Security						
		020). The review indicated a						
	-	ontact and obtain Social						
		as attempted in May 2022. The						
		cate attempts to follow up or						
	complete the proces	ss of obtaining social security						

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 03/21/2023 15G353 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1012 PARKWAY DR **REM OCCAZIO LLC** ANDERSON, IN 46012 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE benefit for client B following the attempts in April 2020 or May 2022. The review indicated a third attempt to contact Social Security Administration and obtain social security benefits for client B was completed in January 2023 and SSC #1 was working with the Social Security Administration to complete the process of obtaining Social Security benefits for client B. Client B's record was reviewed on 3/16/23 at 9:11 AM. Client B's RMFS stated dated 3/1/22 through current did not indicate documentation of any deposits pertaining to client B's social security benefits. An email correspondence from SSC #1 dated 3/16/23 was reviewed on 3/16/23 at 10:14 AM. The email correspondence indicated the following: -"...[Client B] lost his benefits because the SSA (Social Security Administration) sent a document to be completed, and it was not returned. The SSA did not tell me (SSC #1) what the document was. When his benefits were suspended, the decision was not appealed, so they were stopped altogether. I completed this interview to reapply for benefits ... ". SSC #1 was interviewed on 3/16/23 at 2:16 PM. SSC #1 was asked if she had any documentation regarding the application and status of client B's attempts to obtain social security benefits when he first moved into Indiana Mentor's services. SSC #1 stated, "No." SSC #1 indicated she had only been working in the position for a few months and stated, "First email I got about him (client B) was January 17th (2023). I filed for rep payee and social security benefits for [client B] on FG7911 Event ID: Facility ID: 000869 Page 6 of 18 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G353	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 03/21/2023				
	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1012 PARKWAY DR					
REMOC	CAZIO LLC		ANDER	SON, IN 46012					
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETIO			
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCE		DATE			
	took over, was the her regarding prior security benefits for she did not receive "I just have what I in January and hav keep a tracker so I what I am doing b	3)." SSC #1 was asked when she re any paperwork provided to r attempts of obtaining social or [client B]. SSC #1 indicated e any paperwork. SSC #1 stated, have started when I took over re been working on it. Now I could keep dates regarding ut if people before me didn't tation I have nothing to go off							
	3/16/23 at 12:36 P facility's policy/pre- to obtaining social admission. RD #1 admitted, if the far payee, we as the p the payee process. facility obtaining s payee for client B. moved in with us i were made. I'll be requests we made. Coordinator at the didn't keep the cor from back then. He Coordinator) is no performance issue requesting/comple think we did drop Social Security Co dropped (obtaining client B)." RD #1 Security Coordina client B since Janu complete the proce	ector) #1 was interviewed on M. RD #1 was asked about the ocedure and timeline pertaining security for a client upon stated, "When an individual is nily chooses us to become rep rovider are supposed to start " RD #1 was asked about the social security benefits and rep RD #1 stated, "He (client B) n October 2019. The requests honest we didn't keep all the Our Social Security time is no longer with us and I munication we had with him e (Former Social Security longer with us because of s and not ting things in a timely manner. I the ball. We have changed bordinators four times and it was g the social security benefits for indicated the new SSC (Social tor) had been working with eary and has continued to ess for obtaining his social RD #1 was asked if the facility ation pertaining to the status of							

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 15G353	ATION NUMBER A. BUILDING <u>00</u> B. WING		
	PROVIDER OR SUPPLIEF	ł	1012 F	ADDRESS, CITY, STATE, ZIP COD PARKWAY DR RSON, IN 46012	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF client B's social sec	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Purity benefits when first	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
N 0159 Bldg. 00	gone through, we sl indicating his appli and would have out have been to live in received a letter and where the letter is." should have follow process of obtaining benefits when he fit This federal tag rela 9-3-1(a) 483.430(a) QIDP Each client's activ be integrated, coo a qualified intellect who- Based on record rev sampled clients (B) Intellectual Disabil ensure oversight ov benefits. Findings include: The facility's QIDP client B's social sec W104.	stated, "Had the application hould have received a letter cation was accepted or denied thined what his liability would a our home. We should have d I don't know if we did, or RD #1 indicated the facility ed up and completed the g client B's social security rst moved in. ates to complaint #IN00401300. The treatment program must ordinated and monitored by ctual disability professional view and interview for 1 of 3 , the facility's QIDP (Qualified ities Professional) failed to the client B's social security failed to ensure oversight of ourity benefits. Please see ates to complaint #IN00401300.	W 0159	W159- QIDP Based on record review and interview for 1 of 3 sampled clien (B), the facility's QIDP (Qualified Intellectual Disabilities Professional) failed to ensure oversight over client B's social security benefits 1. What corrective action will be accomplished? • Program Director and Area Director will do an audit of all individuals' benefits. They will wo with individual funds specialists t ensure they have necessary information/documents to ensure benefits are active. • Program Director and Area	ork o

	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G353	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/21/2023	
NAME OF P	ROVIDER OR SUPPLIE	R	STREET 1012 P			
REM OCO	REM OCCAZIO LLC		ANDEF	RSON, IN 46012		
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	 Director will have regular follow meetings with individual funds specialist/intake coordinators to ensure new admissions have benefits in place rep payeeship paperwork submitted promptly etc. Will ensure that Client Bs social security benefits have bereinstated. How will we identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be take. All residents have the potential to be affected by the same deficient practice. Program Director and Are Director will do an audit of all individuals' benefits. They will with individual funds specialist ensure they have necessary information/documents to ensure they have regular follow meetings with individual funds specialist ensure they admissions have benefits in place rep payeeship paperwork submitted promptly etc. Will ensure that Client Bs social security benefits have breinstated. 	so p seen er al n? ea work s to ure ea w up so p ', seen	

	T OF DEFICIENCIES DF CORRECTION	x1) provider/supplier/clia identification number 15G353		JILDING	ONSTRUCTION 00	CO	(X3) DATE SURVEY COMPLETED 03/21/2023	
	ROVIDER OR SUPPLIE	R	-	STREET 1012 P	•			
REM OC	CAZIO LLC			ANDE	RSON, IN 46012			
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					 changes will be made to ensure that the deficient practice does not recur: Program Director and Director will do an audit of individuals' benefits. They with individual funds speciensure they have necessar information/documents to benefits are active. Program Director and Director will have regular formation/documents to benefits are active. Program Director and Director will have regular formations with individual furspecialist/intake coordinate ensure new admissions have benefits in place rep paye paperwork submitted prometre. How will the correct action be monitored to east the deficient practice will recur? Program Director and Director will do an audit of individuals' benefits. They with individual funds speciensure they have necessar information/documents to benefits are active. Program Director and Director will have regular formation/documents to benefits are active. Program Director and Director will have necessar information/documents to benefits are active. With individual funds speciensure they have necessar information/documents to benefits are active. Wrogram Director and Director will have regular formation/documents to benefits in place rep paye paperwork submitted prometre. Will ensure that Clier social security benefits har reinstated. 	d Area all will work alists to rry ensure d Area follow up inds ors to ave eship aptly, ive not d Area all will work alists to rry ensure d Area all will work alists to rry ensure d Area all will work alists to rry ensure d Area all will work alists to rry ensure d Area all will work alists to rry ensure		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G353	A. BU	2) MULTIPLE CONSTRUCTION X A. BUILDING <u>00</u> B. WING		COMI	(X3) DATE SURVEY COMPLETED 03/21/2023	
	PROVIDER OR SUPPLIE	R		1012 P	address, city, state, zip cod ARKWAY DR RSON, IN 46012			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON 9 BE 9 PRIATE	(X5) COMPLETION DATE	
TAG W 0249 Bldg. 00	483.440(d)(1) PROGRAM IMPI As soon as the ir formulated a client each client must treatment progra interventions and number and freque achievement of the individual program Based on record re sampled clients (A client A's BSP (Be implemented as we Findings include: The facility's BDD Disabilities Servic were reviewed on indicated the follow A BDDS reported 2/7/23 an individue home] reported to witnessed house st chair with a gait be running around the and throwing item around him and the	LEMENTATION Interdisciplinary team has int's individual program plan, receive a continuous active m consisting of needed l services in sufficient uency to support the ne objectives identified in the m plan. wiew and interview for 1 of 3), the facility failed to ensure havioral Support Plan) was ritten.	wo		 Program Director and Director will have retraining benefits processes What is the date by we the systemic changes will completed? 4-21-2023 W249 – program implement Based on record review are interview for 1 of 3 sample (A), the facility failed to ensi- client A's BSP (Behavioral Plan) was implemented as What corrective action will be accomplished? The Program Supervit do home observations were ensure staff are implement plans of clients and the clien needs are being met. The Program Director Area Director will do home observations bi-weekly to en- staff are implementing the clients and the client's nee- being met. Staff training will be completed regarding ISPs/ 	g on which I be I be ntation id d clients sure Support written. on sor will ekly to ing the ent's and/or ensure plans of ds are	04/21/202:	

OF CORRECTION	IDENTIFICATION NUMBER 15G353	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING STREET ADDRESS, CITY, STATE, ZIP, C		00	(X3) DATE SURVEY COMPLETED 03/21/2023		
	R	1	STREET ADDRESS, CITY, STATE, ZIP COD 1012 PARKWAY DR ANDERSON IN 46012				
	STATEMENT OF DEFICIENCIE			- ,		(V5)	
				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
				CROSS-REFERENCED TO THE APPROPRIATE	Ē		
		11	AG			DATE	
-							
					rior		
				approval and ID1 meeting.			
Director), AD (Are	ea Director) notified".			• • • • • • • •			
				-			
```	•						
e	ion) dated 2/14/23 indicated the			-			
following:				•	_		
					?		
-	ent A's] ISP that he requires a			-			
U U				- ·			
				-			
	gait belt on him to prevent				he		
e				plans of clients and the client's			
				needs are being met.			
had been trained or	n [client A's] BSP.			<ul> <li>The Program Director and</li> </ul>	/or		
				Area Director will do home			
Site Visits				observations bi-weekly to ensur	re		
	· •			staff are implementing the plans	s of		
Supervisor) and ch	air to restrain individual (client			clients and the client's needs ar	re		
A is taller and larg	er than the PS)			being met.			
				<ul> <li>Staff training will be</li> </ul>			
Interview				completed regarding ISPs/BSP	s		
02/10/2023				of the individuals in the home.			
[Staff #2]				o Follow BSPs as written and		1	
				not changing the plan without p	rior		
	-			approval and IDT meeting.			
drinking other peop	ple's drinks						
[Staff #2] stated he	had to take the trash out and						
was worried that [c	client A] would run off.			3. What measures will be		1	
				put into place or what systemi	ic		
A's] waist in case h	he ran off he (staff #2) could			changes will be made to		1	
				ensure that the deficient			
[Staff #2] stated he	e sat [client A] in a chair in front			practice does not recur:			
of the front door w	hile he (staff #2) took the trash			· The Program Supervisor w	vill		
out.						1	
[Staff #2] stated he	e did not tie or secure [client A]			-			
to the chair.							
	CAZIO LLC SUMMARY (EACH DEFICIE) REGULATORY O immediately. Invest on abuse and negle scheduled. PS (Pro- Director), AD (Ard TMNRFII (The M- Internal Investigati following: -"Documents or I ISP (Individual Su documented in [cli gait belt. BSP (Behavior Sup A's] BSP to strap a vacating. Training's (sic) - It had been trained or Site Visits Yes. Gait belt coul Supervisor) and ch A is taller and larg Interview 02/10/2023 [Staff #2] [Staff #2] stated he was worried that [c [Staff #2] stated he stop him from (sic] [Staff #2] stated he of the front door wo out. [Staff #2] stated he of the front door wo out. [Staff #2] stated he	PROVIDER OR SUPPLIER CAZIO LLC SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL <u>REGULATORY OR LSC IDENTIFYING INFORMATION</u> immediately. Investigation started. Staff training on abuse and neglect, reporting, and restraints scheduled. PS (Program Supervisor), PD (Program Director), AD (Area Director) notified". TMNRFII (The Mentor Network Report Form for Internal Investigation) dated 2/14/23 indicated the following: -"Documents or Files Reviewed ISP (Individual Support Plan) - It is not documented in [client A's] ISP that he requires a gait belt. BSP (Behavior Support Plan) - It is not in [client A's] BSP to strap a gait belt on him to prevent vacating. Training's (sic) - It is documented that [staff #1] had been trained on [client A's] BSP. Site Visits Yes. Gait belt could not fit around PS (Program Supervisor) and chair to restrain individual (client A is taller and larger than the PS) Interview 02/10/2023 [Staff #2] [Staff #2] stated [client A] had been having behaviors of running around the house and drinking other people's drinks [Staff #2] stated he had to take the trash out and was worried that [client A] would run off. [Staff #2] stated he put a gait belt around [client A's] waist in case he ran off he (staff #2) could stop him from (sic) grabbing onto the bait belt. [Staff #2] stated he sat [client A] in a chair in front of the front door while he (staff #2) took the trash out. [Staff #2] stated he did not tie or secure [client A]	PROVIDER OR SUPPLIER       S         CAZIO LLC       A         SUMMARY STATEMENT OF DEFICIENCIE       In         (EACH DEFICIENCY MUST BE PRECEDED BY FULL       PRI         REGULATORY OR LSC IDENTIFYING INFORMATION       T         immediately. Investigation started. Staff training       on abuse and neglect, reporting, and restraints         scheduled. PS (Program Supervisor), PD (Program       Director), AD (Area Director) notified".         TMNRFII (The Mentor Network Report Form for       Internal Investigation) dated 2/14/23 indicated the         following:       -"Documents or Files Reviewed         ISP (Individual Support Plan) - It is not       documented in [client A's] ISP that he requires a         gait belt.       BSP (Behavior Support Plan) - It is not in [client         A's] BSP to strap a gait belt on him to prevent       vacating.         Training's (sic) - It is documented that [staff #1]       had been trained on [client A's] BSP.         Site Visits       Yes. Gait belt could not fit around PS (Program         Supervisor) and chair to restrain individual (client       A is taller and larger than the PS)         Interview       02/10/2023         [Staff #2]       stated [client A] had been having         behaviors of running around the house and       drinking other people's drinks         [Staff #2] stated he had to take the trash ou	ROVIDER OR SUPPLIER       STREET A         CAZIO LLC       SUMMARY STATEMENT OF DEFICIENCIE       ID         REGULATORY OR LSC IDENTIFYING INFORMATION       TAG         immediately. Investigation started. Staff training       On abuse and neglect, reporting, and restraints         scheduled. PS (Program Supervisor), PD (Program       Director), AD (Area Director) notified".         TMNRFII (The Mentor Network Report Form for       Internal Investigation) dated 2/14/23 indicated the         following:       -"Documents or Files Reviewed       ISP (Individual Support Plan) - It is not         documented in [client A's] ISP that he requires a       gait belt.         BSP (Behavior Support Plan) - It is not in [client       A's] BSP to strap a gait belt on him to prevent         vacating.       Training's (sic) - It is documented that [staff #1]         had been trained on [client A's] BSP.       Site Visits         Yes. Gait belt could not fit around PS (Program       Supervisor) and chair to restrain individual (client         A is taller and larger than the PS)       Interview         02/10/2023       [Staff #2]         [Staff #2] stated [client A] had been having       behaviors of running around the house and         drinking other people's drinks       [Staff #2] stated he had to take the trash out and         was worried that [client A] would run off.       [Staff #2] stated he had to take	ROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZP COD 1012 PARKWAY DR ANDERSON, IN 46012         CAZIO LLC       ID         SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION       ID         Immediately, Investigation started. Staff training on abuse and neglect, reporting, and restraints scheduled. PS (Program Supervisor), PD (Program Director), AD (Area Director) notified".       D         TMNRFII (The Mentor Network Report Form for Internal Investigation) dated 2/14/23 indicated the following:       O       Follow BSPs as written and not changing the plan without p approval and IDT meeting.         "Documents or Files Reviewed ISBY (Individual Support Plan) - It is not in documented in [client A's] ISP that he requires a gait belt.       O       All residents have the potential to be affected by the same deficient practice and what corrective action will be taken · All residents have the potential to be affected by the same deficient practice and what corrective action will be taken · The Program Director and Area Director will do home observations biweekly to ensu staff are implementing the plan: Site Visits         Yes. Gait belt could not fit around PS (Program Supervisor) and chair to restrain individual (client A is taller and larger than the PS)       · The Program Director and Area Director will do home observations biweekly to ensu staff are implementing the plan: clients and the client's needs ar being met.         Staff #2] stated [client A] hab been having behaviors of running around the house and drinking other people's drinks [Staff #2] stated he lua to kake the trash out and was woried that [client A] would run off. [Sta	ROVIDER OR SUPPLIER         STREFT ADDRESS, CITY, STATE, ZIP COD 1012 PARKWAY DR ANDERSON, IN 46012           CAZIO LLC         ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECOLLATORY OR LISC IDENTIFYING INFORMATION on abuse and neglect, reporting, and restraints scheduled. PS (Program Supervisor), PD (Program Director), AD (Area Director) notified".         ID (PROVIDER SPLANOF CONSTRUCTION DEFICIENCY TAG           TMNRFI (The Mentor Network Report Form for Internal Investigation) dated 2/14/23 indicated the following:         O         Follow BSPs as written and not changing the plan without prior approval and IDT meeting.           -"Documents or Files Reviewed ISP (Individual Support Plan) - It is not documented in [client A's] ISP that he requires a gait belt.         O         How will we identify other residents have the potential to be affected by the same deficient practice.           Site Visits Yes. Gait belt could not fit around PS (Program Site Visits Yes. Gait belt could not fit around PS (Program Site Visits.         - The Program Supervisor will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met.           - Staff training will be completed regarding ISPs/BSPs of the individuals in the home. o Staff #2] stated he bat gaits belt around [Client A's] waist in case he ran off he (staff #2) could stop thing outper people's drinks [Staff #2] stated he bat gaits belt around [Client A's] waist in case he ran off he (staff #2) could stop tim from (sic) grabbing ont the buit belt. [Staff #2] stated he bat do take the trash out.         3. What measures will be put into place or what systemic changes will be made to ensure taff are implementing the plans without prior approval and IDT meeting.	

FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED: 05/08/2023 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES	;
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AND PLAN OF CORRECTION IDEN		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILDING	construction c	(X3) DATE SURVEY COMPLETED	
15G353			B. WING		03/21/2023	
NAME OF	PROVIDER OR SUPPLIE	R		TADDRESS, CITY, STATE, ZIP COD PARKWAY DR		
REM OC	CAZIO LLC			RSON, IN 46012		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETIO	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	[Staff #2] stated [c	lient A] was able to undo the		needs are being met.		
	gait belt			• The Program Director and	/or	
		lient A] had the gait belt on just		Area Director will do home		
	for him ([staff #2])	) to take the trash out		observations bi-weekly to ensur		
				staff are implementing the plans		
	Interview			clients and the client's needs ar	e	
	02/06/2023			being met.		
	[Staff #3]			Staff training will be		
		she seen (sic) [client A] with a		completed regarding ISPs/BSP	s	
	gait belt on as she was walking to the med			of the individuals in the home.		
	(medication) room but he was not tied to			o Follow BSPs as written and		
	anything			not changing the plan without p approval and IDT meeting.	rior	
	Conclusions of Fa	ct				
	Evidence supports	staff put a gait belt on [client				
	A] although it was not written in his BSP			4. How will the corrective		
	(Behavioral Suppo	ort Plan) or Risk Plan that he		action be monitored to ensure	•	
	should use which i rights.	s a restriction of [client A's]		the deficient practice will not recur?		
	-	that the intent of the staff		• The Program Supervisor w	vill	
		e gait belt as a method to		do home observations weekly to		
	-	from vacating is not an		ensure staff are implementing the		
	approved intervention".			plans of clients and the client's		
				needs are being met.		
	Client A's record w	vas reviewed on 3/15/23 at 11:22		The Program Director and	/or	
	AM.			Area Director will do home		
				observations bi-weekly to ensur	e	
	Client A's BSP dat	ted 12/13/22 did not include the		staff are implementing the plans	s of	
	intervention of usi	ng a gait belt for behavioral		clients and the client's needs ar	e	
	intervention or rea	ctive strategy.		being met. · Staff training will be		
	Client B was inter	viewed on 3/15/23 at 7:24 AM.		completed regarding ISPs/BSPs	s	
		d about incident involving client		of the individuals in the home.		
	A and staff placing a gait belt around him (client			o Follow BSPs as written and		
	A). Client B stated, "Staff (staff #2) put a belt			not changing the plan without p	rior	
	around [client A] and sat him in a chair." Client B			approval and IDT meeting.		
	indicated the belt was placed around client A's			New staff hired to work at	the	
		ted, "[Client A] doesn't need a		site will receive client specific		
		ff (staff #2) just put it around		training for each individual prior	to	
	[client A] to help s	top him (client A) from running		working a shift. This training		

Event ID: FG7911 Facility ID: 000869

If continuation sheet Page 13 of 18

STATEMENT OF DEFICIENCIES			(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED 03/21/2023	
NAME OF PROVIDER OR SUPPI	IER	1012 F	ADDRESS, CITY, STATE, ZIP ( PARKWAY DR RSON, IN 46012	COD		
<ul> <li>(X4) ID SUMMA</li> <li>PREFIX (EACH DEFIC TAG REGULATORY around and throw clothes." Client used (use of the and stated, "Staff A) or sit with hit Staff #1 was into Staff #1 was into Staff #1 indicate utilized a gait be trained to utilized #1 was asked if unapproved inte having presentir "No."</li> <li>PS (Program Su 3/15/23 at 8:30 does not use a g here use a gait b never utilize an or restraint.</li> <li>QIDP (Qualified Professional) #1 9:55 AM. QIDP group home hav measures that in restraints. QIDP asked if any of t utilize a gait bel was asked of sta any other adapti</li> </ul>	RY STATEMENT OF DEFICIENCIE IENCY MUST BE PRECEDED BY FULL <u>'OR LSC IDENTIFYING INFORMATION</u> wing things or taking off his B indicated he had never seen it gait belt around client A) before f usually just stay with him (client m until he calms down." erviewed on 3/15/23 at 8:03 AM. d no client at the group home lt. Staff #1 stated, "We are not any (mechanical) restraints." Staff staff should ever utilize an rvention method if a client were g behaviors. Staff #1 stated, pervisor) #1 was interviewed on AM. PS #1 stated, "He (client A) ait belt for anything. No clients elt." PS #1 indicated staff should anapproved intervention method I Intellectual Disabilities was interviewed on 3/16/23 at #1 was asked if any clients at the e any proactive or reactive clude the use of mechanical #1 stated, "No." QIDP #1 was he clients at the group home t. QIDP #1 stated, "No." QIDP #1 ff should ever utilize a gait belt or ve equipment if it is not approved pe utilized in a client's plan. QIDP			stiould be APPROPRIATE s: client's s, BSP's, edication ea Director irrector's sits forms the to ensure the ed. <b>ie by</b>	(X5) COMPLETI DATE	
was not implement	QIDP #1 indicated client A's BSP ented as written. relates to complaint #IN00401402.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 03/21/2023 15G353 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1012 PARKWAY DR **REM OCCAZIO LLC** ANDERSON, IN 46012 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE W 0287 483.450(b)(3) MGMT OF INAPPROPRIATE CLIENT Bldg. 00 **BEHAVIOR** Techniques to manage inappropriate client behavior must never be used for the convenience of staff. Based on record review and interview for 1 of 3 W 0287 W287 - MGMT of inappropriate 04/21/2023 sampled clients (A), the facility failed to ensure client behavior staff utilized only appropriate behavioral Techniques to manage management techniques as indicated in client A's inappropriate client behavior must BSP (Behavioral Support Plan). never be used for the convenience of staff. This STANDARD is not Findings include: met as evidenced by: W 287 Based on record review and The facility's BDDS (Bureau of Developmental interview for 1 of 3 sampled clients Disabilities Services) reports and investigations (A), the facility failed to ensure were reviewed on 3/14/23 at 11:45 AM and staff utilized only appropriate indicated the following: behavioral management techniques as indicated in client A BDDS reported dated 2/8/23 indicated, "... On A's BSP (Behavioral Support 2/7/23 an individual from the [name of group Plan). home] reported to staff that on 2/5/23 he (client B) witnessed house staff strapping [client A] to a 1. What corrective action chair with a gait belt. [Client A] has behaviors of will be accomplished? running around the house, stripping off clothes, The Program Supervisor will and throwing items. Staff wrapped a gait belt do home observations weekly to around him and tied it to a chair to prevent him ensure staff are implementing the from those behaviors. [Client A] had no marks or plans of clients and the client's injuries... Staff (staff #2) involved was suspended needs are being met. immediately. Investigation started. Staff training The Program Director and/or on abuse and neglect, reporting, and restraints Area Director will do home scheduled. PS (Program Supervisor), PD (Program observations bi-weekly to ensure Director), AD (Area Director) notified ... ". staff are implementing the plans of clients and the client's needs are TMNRFII (The Mentor Network Report Form for being met. Internal Investigation) dated 2/14/23 indicated the Staff training will be following: completed regarding ISPs/BSPs of the individuals in the home. -"...Documents or Files Reviewed o Follow BSPs as written and ISP (Individual Support Plan) - It is not not changing the plan without prior FG7911 Event ID: Facility ID: 000869 Page 15 of 18 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

05/08/2023

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STATEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER         15G353		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
			A. BUILDING <u>00</u> B. WING		COMPLETED 03/21/2023	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
REM OC	CAZIO LLC			PARKWAY DR RSON, IN 46012		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	-	ent A's] ISP that he requires a		approval and IDT meeting.		
	gait belt.			<ul> <li>Staff that conducted</li> </ul>		
	BSP (Behavior Su	pport Plan) - It is not in [client		inappropriate restraint will be		
	A's] BSP to strap a	a gait belt on him to prevent		retrained on PIA as well.		
	vacating.					
	Training's (sic) - It	is documented that [staff #1]		2. How will we identify other		
	had been trained o	n [client A's] BSP.		residents having the potential		
				to be affected by the same		
	Site Visits			deficient practice and what		
	Yes. Gait belt coul	d not fit around PS (Program		corrective action will be taken?		
	Supervisor) and ch	air to restrain individual (client		· All residents have the		
	A is taller and larg	er than the PS)		potential to be affected by the		
	_			same deficient practice.		
	Interview			The Program Supervisor wi	I	
	02/10/2023			do home observations weekly to		
	[Staff #2]			ensure staff are implementing the	e	
	[Staff #2] stated	[client A] had been having		plans of clients and the client's		
		ng around the house and		needs are being met.		
	drinking other peo	-		• The Program Director and/o	or	
		e had to take the trash out and		Area Director will do home		
		client A] would run off.		observations bi-weekly to ensure		
	-	e put a gait belt around [client		staff are implementing the plans		
		he ran off he (staff #2) could		clients and the client's needs are		
	-	) grabbing onto the bait belt.		being met.		
		e sat [client A] in a chair in front		· Staff training will be		
		while he (staff #2) took the trash		completed regarding ISPs/BSPs		
	out.			of the individuals in the home.		
	[Staff #2] stated he	e did not tie or secure [client A]		o Follow BSPs as written and		
	to the chair.	L J		not changing the plan without pri	or	
		lient A] was able to undo the		approval and IDT meeting.		
	gait belt	-		• Staff that conducted		
	U	lient A] had the gait belt on just		inappropriate restraint will be		
		) to take the trash out		retrained on PIA as well.		
	Interview			3. What measures will be		
	02/06/2023			put into place or what systemic		
	[Staff #3]			changes will be made to		
	[Staff #3] stated	she seen (sic) [client A] with a		ensure that the deficient		
	gait belt on as she	was walking to the med	practice does not recur:			
	(medication) room but he was not tied to			The Program Supervisor wi	I	

STATEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER         15G353		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
			A. BUILDING <u>00</u> B. WING		COMPLETED 03/21/2023
NAME OF 1	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	
REM OC	CAZIO LLC			PARKWAY DR RSON, IN 46012	
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
	anything			do home observations weekly to	
				ensure staff are implementing th	
	Conclusions of Fa	ct		plans of clients and the client's	
		staff put a gait belt on [client		needs are being met.	
				The Program Director and/	or
	A] although it was not written in his BSP (Behavioral Support Plan) or Risk Plan that he			Area Director will do home	
	· · ·	is a restriction of [client A's]		observations bi-weekly to ensure	e
	rights.	a restriction of [enent res]		staff are implementing the plans	
	-	that the intent of the staff		clients and the client's needs are	
		e gait belt as a method to		being met.	
	-	-		• Staff training will be	
	prevent [client A] from vacating is not an approved intervention".			completed regarding ISPs/BSPs	
	approved intervent			of the individuals in the home.	
	Client Als record y	$\frac{1}{2}$		o Follow BSPs as written and	
	Client A's record was reviewed on 3/15/23 at 11:22 AM.				
	Alvi.			not changing the plan without pr	101
	Climet Als DCD det			approval and IDT meeting.	
		ted 12/13/22 did not indicate		• Staff that conducted	
	or reactive strategy	t belt for behavioral intervention y.		inappropriate restraint will be retrained on PIA as well.	
	Client B was inter-	viewed on 3/15/23 at 7:24 AM.		4. How will the corrective	
	Client B was asked	d about incident involving client		action be monitored to ensure	
	A and staff placing	g a gait belt around him (client		the deficient practice will not	
	A). Client B stated	l, "Staff (staff #2) put a belt		recur?	
	around [client A] a	and sat him in a chair." Client B		· The Program Supervisor w	/ill
	indicated the belt v	was placed around client A's		do home observations weekly to	
	waist. Client B sta	ted, "[Client A] doesn't need a		ensure staff are implementing th	
	belt (gait belt). Sta	ff (staff #2) just put it around		plans of clients and the client's	
	[client A] to help s	stop him (client A) from running		needs are being met.	
	around and throwi	ng things or taking off his		• The Program Director and/	or
		indicated he had never seen it		Area Director will do home	
	used (use of the ga	it belt around client A) before		observations bi-weekly to ensur	e
	and stated, "Staff u	usually just stay with him (client		staff are implementing the plans	
	A) or sit with him until he calms down."			clients and the client's needs are	
				being met.	
	Staff #1 was interviewed on 3/15/23 at 8:03 AM.			· Staff training will be	
	Staff #1 indicated no client at the group home			completed regarding ISPs/BSPs	s
	utilized a gait belt. Staff #1 stated, "We are not			of the individuals in the home.	
		ny (mechanical) restraints." Staff		o Follow BSPs as written and	
		aff should ever utilize an		not changing the plan without pr	ior

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATH	E SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G353		IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		B. WING		03/21/2023		
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
				ARKWAY DR		
REM OC	CCAZIO LLC		ANDEF	RSON, IN 46012		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTIO	DN	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE PRIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	unapproved intervention method if a client were		approval and IDT meet		•	
	0. U	behaviors. Staff #1 stated,		• New staff hired to work at the		
	"No."			site will receive client speci		
	DS (Drogram Sure	rvisor) #1 was interviewed on		training for each individual working a shift. This training	-	
		A. PS #1 stated, "He (client A)		includes items such as: client's		
		belt for anything. No clients		diets, risk plans, ISP's, BSF		
		" PS #1 indicated staff should		programming, and medicat		
	-	approved intervention method		review.		
	or restraint.	11		• On-going the Area Dir	ector	
				will review Program Directo		
	QIDP (Qualified In	ntellectual Disabilities		weekly supervisory visits for	orms	
	Professional) #1 w	as interviewed on 3/16/23 at		and will follow up with the		
	9:55 AM. QIDP #	was asked if any clients at the		appropriate individual to en	sure the	
	0 1	ny proactive or reactive ide the use of mechanical		concerns are addressed.		
	restraints. QIDP #	l stated, "No." QIDP #1 was		5. What is the date by		
	asked if any of the clients at the group home			which the systemic chang	es	
	utilize a gait belt.	QIDP #1 stated, "No." QIDP #1		will be completed		
		should ever utilize a gait belt or		4-21-2023		
		equipment if it is not approved				
	or addressed to be	utilized in a client's plan.				
	This federal tag re	ates to complaint #IN00401402.				
	9-3-5(a)					

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