STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. B	A. BUILDING 00 COM		COMPL	ETED
		15G353	B. W	B. WING 06/08/2021			/2021
				CTREET	ADDRESS OF A TE ZID CODE		
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
DEM OC	REM OCCAZIO LLC				ARKWAY DR		
REM OC	CAZIO LLC			ANDER	RSON, IN 46012		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W 0000							
Bldg. 00							
		he investigation of complaint	W (0000			
		s visit included a Covid-19					
	focused infection c	ontrol survey.					
	_ ,						
	-	53635: Substantiated, Federal					
		les related to the allegation(s)					
	are cited at W149,	W153, W154 and W157.					
	D (CC I	2 2 4 7 10 2021					
	Dates of Survey: Ju	ine 2, 3, 4, 7 and 8, 2021.					
	Facility Number: 0	00860					
	Provider Number:						
	AIMS Number: 10						
	Alivis Number. 100	0244230					
	These deficiencies	also reflect state findings in					
	accordance with 46						
		this report completed by					
	#15068 on 6/21/21.						
W 0149	483.420(d)(1)						
	STAFF TREATM	ENT OF CLIENTS					
Bldg. 00	The facility must o	develop and implement					
	written policies ar	nd procedures that prohibit					
	mistreatment, neg	glect or abuse of the client.					
	Based on record rev	view and interview for 2 of 3	W ()149	1. What corrective action v	vill	07/08/2021
	sampled clients (A	and C) plus 3 additional			be accomplished?		
	clients (E, G and H), the facility failed to			· The Program Supervisor		
	_	ey and procedures to prevent			do home observations weekly		
	-	of physical aggression by FC			ensure staff are implementing		
		A, failed to report incidents of			plans of clients, the client's ne	eds	
		ression to BDDS (Bureau of			are being met and meal		
	-	sabilities Services) within 24			observations.		
	_	e, failed to thoroughly			The Program Director wil	I do	
		d incidents of physical			home observations weekly to		
		A and failed to implement			ensure staff are implementing		
		e measures to prevent			plans of clients, the client's ne	eds	
	repeated incidents	of physical aggression by FC			are being met and meal		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement 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.

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15G353	B. Wl	NG		06/08/	2021
				CTREET	ADDRESS CITY STATE ZID SODE		-
NAME OF P	ROVIDER OR SUPPLIEI	3			ADDRESS, CITY, STATE, ZIP CODE		
551100	0.4.710.11.0				ARKWAY DR		
REM OC	CAZIO LLC			ANDER	RSON, IN 46012		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	.16	DATE
	A.				observations.		
					· Staff meeting/training will	l be	
	Findings include:				completed by the Area Directo	or,	
	_				Program Director and Behavio	or	
	The facility's BDD	S reports and investigations			Support Supervisor regarding:		
	were reviewed on 6	5/2/21 at 9:26 AM.			Former Client A's BSP, behav	ior	
					documentation and reportable	!	
	1. A BDDS report of	dated 1/15/21 indicated on			events. Training to ensure		
	1/13/21, " Staff re	eported that while they were			reporting is done at the		
	in the kitchen putting	ng away groceries another			appropriate times for future		
	individual in the gr	oup home stated that [FC A]			events.		
	bit [client C]. Staff	went to check on the			· The Program Supervisor		
	individuals and the	Program Supervisor (PS) was			and Program Director will revi	ew	
	already there. [FC A	A] wanted the phone while			progress notes two times wee	kly	
	[client C] was still	using it. It was not [FC A's]			for 4 weeks to be sure there a	re	
	turn to use the phor	ne. This upset [FC A] and he			not any incidents noted by the	:	
	bit [client C] on the	e arm. [Client C] scratched [FC			direct support staff that were r	not	
	A] on the hand. The	e Program Supervisor was able			reported per the BDDS reporti	ng	
	to separate both inc	lividuals. Both individuals			policy. On-going the Program		
	were checked for ir	njuries. [Client C] had a red			Supervisor will review progres	s	
	mark on his arm an	d [FC A] had a minor scratch			notes weekly for completenes	s	
	· ·	was washed. Both individuals			and content.		
		o other activities. [Client C]			· The Behavior Clinician w	ill	
		bhone and [FC A] was walking			review and monitor behavior		
	-	when he saw [client G] standing			documentation weekly.		
	-	FC A] walked up to [client G]			· Former Client A's BSP w		
	-	shoulder. [Client G] did not			revised to address his aggress		
		am supervisor stated that this			towards peers and was moved	b	
		our housemates and [FC A]			from home on 5-14-2021.		
		nt G]. [Client G] was checked			· Training will be complete	d	
	for injuries and nor	ne were found."			with the Program Director on		
					incident reporting and		
	-A review of the BDDS report dated 1/15/21				investigation requirements.		
	indicated FC A bit client C and pushed client G.				The IDT has met to discu	ISS	
	The review did not indicate documentation of an				Former Client A's behavioral		
	investigation regarding the client to client				concerns. The IDT meets a		
	aggression by FC A towards clients C and G.				minimum of bi-weekly and who	en	
	0.4.0000				necessary weekly.		
	-	dated 1/20/21 indicated on			Former Client A has been	n	
į	[1/19/21, " [FC A]	and [client E] were eating			evaluated by Nueropsych		

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15G353	B. W	ING		06/08/	2021
				CENTER	ADDRESS STEV STATE TIP SODE		
NAME OF I	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP CODE		
					ARKWAY DR		
REM OC	CAZIO LLC			ANDER	RSON, IN 46012		
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.16	DATE
	dinner with the rest	of the individuals on the			Indianapolis since events.		
	evening on 1/19/21.	. Staff reported that [FC A]			Medicine changes have been		
	was not sharing the fruit with the other				implemented. Former Client A	has	
	individuals. [Client E] asked [FC A] to please				been moved to a new home a	nd is	
	pass the fruit to him. [FC A] refused to share the				currently working with BDDS t	0	
	fruit and hit [client E]. Staff intervened and [FC				move into a waiver home.		
	A] stopped. Staff re	eminded [FC A] that we do not					
	put our hands on ot	her individuals. Staff asked					
	1 ~	hands to himself. Staff					
		for injuries, a red mark was			2. How will we identify oth	er	
	found, but later fade	ed away IDT			residents having the potential	al	
	(Interdisciplinary T	eam) meets weekly to discuss			to be affected by the same		
	[FC A's] behavior a	and meets to discuss [client E]			deficient practice and what		
	when needed".				corrective action will be take	n?	
					· All residents have the		
	-A review of the BI	ODS report dated 1/20/21			potential to be affected by the		
	indicated an incider	nt of client to client			same deficient practice.		
	aggression occurred	d between FC A and client E.			· The Program Supervisor	will	
	The review did not	indicate documentation of an			do home observations weekly	to	
	investigation regard	ling this incident of client to			ensure staff are implementing	the	
	client aggression.				plans of clients, the client's ne	eds	
					are being met and meal		
	3. A BDDS report of	lated 1/29/21 indicated on			observations.		
	1/25/21, " Staff re	eported that while in the			· The Program Director wi	ll do	
	kitchen with some of	of the individuals, [FC A]			home observations weekly to		
	•	hysically aggressive. [Client			ensure staff are implementing		
		front of [FC A] and [FC A]			plans of clients, the client's ne	eds	
		Client C] saw this and hit [FC			are being met and meal		
	A] . Staff tried redin	recting all 3 individuals and			observations.		
		C A] began being verbally			· Staff meeting/training wil		
	,	ing at [client C]. [Client C] hit			completed by the Area Directo		
		hit him back, then [FC A] left			Program Director and Behavio		
	_	C] followed him (FC A) out			Support Supervisor regarding:		
	of the kitchen and both individuals continued				Former Client A's BSP, behav		
	hitting each other. Staff prompted them to stop				documentation and reportable	!	
	and after the second verbal prompt, they				events. Training with staff on		
	separated and were able to be redirected. Staff				importance of reporting in a tir	mely	
		idual for injuries and none			manner for future events.		
	were found IDT n	neets weekly to discuss [FC			· The Program Supervisor		
	A's] behavior and n	neets to discuss [client E] and			and Program Director will revi	ew	

TYJS11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED
		15G353	B. W	ING		06/08/2021
		<u> </u>		CTREET	ADDRESS CITY STATE ZID CODE	
NAME OF P	PROVIDER OR SUPPLIE	₹			ADDRESS, CITY, STATE, ZIP CODE	
DEMOC	CA710 LLC				ARKWAY DR	
REM OC	CAZIO LLC			ANDER	RSON, IN 46012	
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TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	[client C] when needed".				progress notes two times wee	-
					for 4 weeks to be sure there a	re
		DDS report dated 1/29/21			not any incidents noted by the	
	indicated an incider				direct support staff that were r	
		d between FC A and clients C			reported per the BDDS reporti	ng
		did not indicate documentation			policy. On-going the Program	
	~	regarding this incident of			Supervisor will review progres	
		ression. The review did not			notes weekly for completeness	S
	-	reported the incident of			and content.	
		ression occurred between FC			The Behavior Clinician w	111
		I E to BDDS within 24 hours			review and monitor behavior	
	of knowledge.				documentation weekly.	٨
	4 A DDDC	4-4-4-2/11/01 in 4i4-4 - in			Training will be complete	u
		dated 3/11/21 indicated on after and the program supervisor			with the Program Director on incident reporting and	
		te a shower and he refused.			investigation requirements.	
		oming verbally aggressive and			The IDT will continue to r	meet
		to get out and that he was not			to address behavioral concern	
		C A] raised his hand as if he			and client needs as necessary	
		em (staff). [Client H] saw this			· The IDT has implemente	
		he tried stopping [FC A] from			monthly staffings to ensure that	
	-	C A] spit on [client H]. [Client			the team discusses the needs	
	-	FC A] and [FC A] started			the residents in the following	
		I]. [FC A] tried biting [client			areas: home, behavior, IDT's	
		hirt. The program supervisor			needed, family involvement,	
	tried to separate the	e individuals and prompted			medical, workshop/day service	es,
	them to stop fighting	ng. The program supervisor			financial and adaptive equipme	ent.
	prompted the indiv	iduals to stop fighting again.			After the second month the	
	[Client H] stopped	hitting [FC A] and the			Program Director will send a c	юру
	individuals separate	ed and were redirected. The			of the notes to the AD and	
		checked both individuals for			Behavior Supervisor for reviev	V
		had small scratches on his				
		as well as his upper chest. [FC			1.What measures will be pu	ıt
	A] had a small scratch on his leg and hand. Both				into place or what systemic	
	individuals were cleaned up and antibiotic				changes will be made to ens	
	ointment was put on their scratches Staff to				that the deficient practice do	es
	continue to treat individuals' scratches with first				not recur:	القدد
	aid IDT (Interdisciplinary Team) team meet				The Program Supervisor	
		FC A's] behavior and meets to			do home observations weekly	
	discuss [client E] v	viien needed".			ensure staff are implementing	uic

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

Event ID:

TYJS11

Facility ID: 000869

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15G353	B. W	NG		06/08/	/2021
				CTREET	ADDRESS CITY STATE ZIR CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
DEM 00	04710110				ARKWAY DR		
REM OC	CAZIO LLC			ANDER	RSON, IN 46012		
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					plans of clients, the client's ne	eds	
	-A PPAQ (Peer to Peer Aggression Questions)				are being met and meal		
	form dated 3/9/21 a	and completed by PS			observations.		
	(Program Supervisor) #1 indicated the				· The Program Director wi	ll do	
	following:				home observations weekly to		
					ensure staff are implementing		
	-"Please describe w	hat was observed during the			plans of clients, the client's ne	eds	
	incident in detail be	elow:"			are being met and meal		
					observations.		
	-" [FC A] was aske	d to take a shower by staff and			 Staff meeting/training will 	l be	
	[PS #1]."				completed by the Area Directo		
					Program Director and Behavio	or	
	-" [FC A] told staff	get out, he wasn't going. (FC			Support Supervisor regarding	· ·	
	A) started acting lik	te he wanted to hit staff so			Former Client A's BSP, behav	rior	
		(sic) and [FC A] spit on			documentation and reportable	!	
		I] went after [FC A] and they			events. Training with staff on		
		lient H] got [FC A] on the			importance of reporting in a tir	nely	
	_	ng him. PS (#1) tried to get			manner for future events.		
		C A]. [Client H] was hitting			· The Program Supervisor		
		was biting and and ripping			and Program Director will revi		
		e (FC A) also scratched his			progress notes two times wee	-	
	(Client H's] nose ar	ea and face"			for 4 weeks to be sure there a		
					not any incidents noted by the		
		been done differently to			direct support staff that were r		
	prevent a future inc	ident?"			reported per the BDDS report	ing	
					policy. On-going the Program		
	, ,	[FC A] needs to stop spitting			Supervisor will review progres		
	on others."				notes weekly for completenes	S	
					and content.		
		AQ form dated 3/9/21			The Behavior Clinician w	'III	
		ame upset when staff asked			review and monitor behavior		
		er. The review indicated when			documentation weekly.	.1	
	FC A threatened to hit staff, client H "intervened"				Training will be complete	ea	
	in an attempt to protect staff. The review				with the Program Director on		
	indicated FC A and client H sustained injuries as				incident reporting and		
	a result of the incident of client to client				investigation requirements.		
	aggression on 3/9/21. The review did not indicate				The IDT will continue to i		
		tion of an investigation			to address behavioral concerr		
		ent of client to client			and client needs as necessary		
	aggression. The rev	riew did not indicate			· The IDT has implemente	a	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15G353	B. WI		<u> </u>	06/08/	
		1.00000				00,00,	
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
					ARKWAY DR		
REM OC	CAZIO LLC			ANDER	RSON, IN 46012		
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	recommendations f	or effective corrective			monthly staffings to ensure th	at	
	measures to prevent further incidents of client to				the team discusses the needs	of	
	client aggression.				the residents in the following		
					areas: home, behavior, IDT's		
	5. A BDDS report dated 3/18/21 indicated on				needed, family involvement,		
	3/15/21, " [Client A] was walking out of his				medical, workshop/day servic	es,	
	bedroom and was w	valking into the bedroom after			financial and adaptive equipm	ent.	
	being prompted by	the Program Supervisor to			After the second month the		
	take a shower. [FC	A] hit [client A] in the back.			Program Director will send a	сору	
	The program super	visor redirected [FC A] and			of the notes to the AD and		
	had him apologize	to [client A]. The program			Behavior Supervisor for review	W.	
	supervisor checked	[client A] for injuries and					
	found none. The pro	ogram supervisor checked			1.How will the corrective		
	[client A] for injure	s and found none. The			action be monitored to ensu	re	
	program supervisor	asked [client A] if he was			the deficient practice will no	t	
	okay and he laughe	d and left the room".			recur?		
					· The Program Supervisor	will	
	A review of the BD	DS report dated 3/18/21			do home observations weekly	to	
	indicated an incider	nt of client to client			ensure staff are implementing	the	
	aggression occurred	d between FC A and client A.			plans of clients, the client's ne	eds	
	The review did not	indicate documentation of an			are being met and meal		
	investigation regard	ling this incident of client to			observations.		
	client aggression. T	he review did not indicate the			· The Program Director wi	ll do	
	facility reported the	incident of client to client			home observations weekly to		
	aggression occurred	d between FC A and client A			ensure staff are implementing	the	
	to BDDS within 24	hours of knowledge. The			plans of clients, the client's ne	eds	
		cate recommendations for			are being met and meal		
	effective corrective	measures to prevent further			observations.		
	incidents of client to	o client aggression.			 New staff hired to work a 	ıt	
					the site will receive client spec	cific	
	6. A BDDS report of	lated 3/21/21 indicated on			training for each individual pri-	or to	
	3/18/21, " [Client	A] reported to staff that			working a shift. This training		
	while in their bedro	om [FC A] pushed him onto			includes items such as: client	S	
	the bed face first. [Client A] told staff that [FC A]				diets, risk plans, ISP's, BSP's	,	
	attempted to pull [client A's] pants down. [Client				programming, and medication	l	
	A] said that he pulled his pants back up and came				review.		
	and reported the incident to staff. Staff checked				· The IDT has implemente	:d	
	[client A] for injuries and made sure that he was				monthly staffings to ensure th	at	
	okay. No injuries w	ere found. Staff spoke with			the team discusses the needs	of	
	[FC A] about not po	atting his hands on or being			the residents in the following		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 15G353 B. WING 06/08/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1012 PARKWAY DR REM OCCAZIO LLC ANDERSON, IN 46012 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) aggressive towards other individuals... IDT areas: home, behavior, IDT's (Interdisciplinary Team) team meet weekly to needed, family involvement, medical, workshop/day services, discuss [FC A's] behavior and meets to discuss financial and adaptive equipment. [client A] when needed...". Oversight of the behavior -A PPAQ (Peer to Peer Aggression Questions) documentation will be completed by the Program Coordinator, form dated 3/18/21 and completed by PS (Program Supervisor) #1 indicated the QIDP, and Behavior Clinician. following: Quarterly Health and Safety assessments will be completed by -"Please describe what was observed during the the Program Coordinator and/or incident in detail below:" the Program Director and forwarded to the Quality Improvement department. These -"[Client A] came and told staff that [FC A] pushed him on the bed where his butt (buttock) assessments include a review of was out and he (client A) was facing the wall and the environmental needs for the tried to pull down his pants. He (client A) said home, review of risk plans, ISP, BSP and client specific training he pulled his pants up and came out in the hallway then went to tell staff. 'He didn't get to pull my for the residents. The assessment underwear down' [client A] said...". also includes an interview of staff to ensure they know how to -"What could have been done differently to properly document, how to report prevent a future incident?" incidents and understanding of BSP's. -"Nothing except for trying to keep a better eye The Quality Improvement on [FC A]." Department and the Area Director will monitor incidents as they are A review of the PPAQ form dated 3/18/21 reported to ensure that they are indicated FC A pushed client A onto a bed and reported timely and that all attempted to pull down clients A's pants. The required incidents are reported to review did not indicate documentation of an BDDS. investigation regarding this incident of client to New staff hired to work at client aggression/sexually inappropriate the site will receive training on behavior. The review did not indicate the facility reportable incidents, reporting reported the incident of client to client expectations and who to contact. aggression/sexually inappropriate behavior The Behavior Clinician will between FC A and client A to BDDS within 24 monitor during their monthly hours of knowledge. The review did not indicate observations. indicate documentation of an investigation On-going the Area Director regarding this incident of client to client will review Program Director's

PRINTED: 07/19/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		î ´	JLTIPLE CO ILDING	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION		B. WI		00	COMPL	
		15G353	D. WII			06/08/	2021
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					ARKWAY DR		
REM OC	CAZIO LLC			ANDER	SON, IN 46012		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY		DATE
	aggression/sexually	inappropriate behavior. The			weekly supervisory visits form	S	
		eate recommendations for			and will follow up with the		
		measures to prevent further			appropriate individual to ensur	e	
	incidents of client to	o client aggression.			the concerns are addressed.		
					Former Client A has been	า	
	•	lated 4/13/21 indicated on			moved to a new home and is		
		A] reported to staff that [FC			currently looking at placement	ın	
		h [client A's] smart TV and			Waiver setting.		
	_	him to stop [FC A] hit [client					
		he room and went to report taff checked [client A] for			1.What is the date by which		
		ure that he was okay. No			the systemic changes will be		
	-	Staff spoke with [FC A]			completed?		
	about not putting hi				July 8th, 2021		
		other individuals IDT team			cary car, 2021		
		scuss [FC A's] behavior and					
		ient A] when needed".					
	-	-					
	-A review of the BI	DDS report dated 4/13/21					
	indicated an incider	nt of client to client					
	aggression occurred	between FC A and client A.					
		indicate documentation of an					
		ing this incident of client to					
		he review did not indicate					
		or effective corrective					
		further incidents of client to					
	client aggression.						
	& A RDDS ranget a	lated 4/19/21 indicated, "					
	_	scratched client C's face. No					
		vas needed. Staff cleaned the					
		ed the nurse and [client C's]					
		e wanted to press charges due					
	-	ons with [client C] about [FC					
		pervisor called the police and					
		report. An alternative					
		ggested to the parents. The					
	guardians of both m	nen did not want to have them					
	go somewhere else	to keep them separated. They					
	were afraid it would	I make them uncomfortable to					
	i						

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Facility ID: 000869

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	ULTIPLE CO. JILDING	NSTRUCTION 00	(X3) DATE COMPL			
		15G353	B. W	ING		06/08/	2021	
	PROVIDER OR SUPPLIER	2	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	be out of their envir a psych (psychiatric recent behaviors an not feel it was need Mom packed him u met and [FC A's] great an evaluation individual's BSPs (I meet biweekly for [I -A PPAQ form date PS (Program Super following: -"Please describe wrincident in detail be seed to be a mediated by the seed	ronment. The team suggested by evaluation for [FC A] due to d his (FC A's) guardian did ed at the time. [Client C's] p for the night The IDT has uardian has agreed to let him Mentor will revise both Behavior Support Plan) and FC A]." 2d 4/18/21 and completed by visor) #1 indicated the clow:" alled me at 4:37 PM. to tell living room and [client C] got (Client C) to shut up. [FC A] they got into a scuffle. c) scratched up. They were e were called by family been done differently to ident?" omes in the living room peers often." d 4/18/21 and completed by the following: that was observed during the						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO JILDING	nstruction 00	(X3) DATE COMPL			
		15G353	B. W	ING		06/08/	2021	
	ROVIDER OR SUPPLIER	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012					
(X4) ID		TATEMENT OF DEFICIENCIES	1	ID	<u> </u>		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	T-	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE.	DATE	
	[Client C] blocked t	[FC A] went to hit [client C]. the hit [FC A] scratched (sic). The fight was able to be						
	-"Was there any inj	ury?"						
	-"(Staff #1) [Client Aid was done (sic).	C] scratches on his face. First						
	-"What could have prevent a future inc	been done differently to ident?"						
	-"Keep them apart."							
	incident of client to FC A and client C or review indicated cli his face. The review asked for the Police C's injuries. The revidocumentation of a review did not indiceffective corrective incidents of client to 9. A BDDS report of 4/23/21," While in	lated 4/25/21 indicated on ndividuals were in the living						
	Services, [FC A] be said a curse word. [at [FC A], but [FC (FC A) would escon A] went over to [cli and [client A] grabb back. Staff came ovindividuals to separ ran out of the room.	came upset when [client A] Client A] was not curing (sic) A] told [client A] to stop or he rt [client A] to his room. [FC rent A] and reached out to him roed [FC A] and bent his fingers rer and prompted the rate and [FC A] then turned and reclient A] chased [FC A] roushed him down, and stomped						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G353		l í	ILDING	NSTRUCTION 00	(X3) DATE : COMPL 06/08/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	on [FC A's] head. B the staff was able to Staff called their pro (Emergency Service evaluated for possib EMS (Emergency N group home. The pot and staff about what go in the ambulance Room), so the Progribe evaluated. [FC A within normal limits assessed him (FC A scratch to the right to back to the group ho Individual Interview indicated the follow -"Individual Interview indicated the follow -"Support Professional -(Staff #2) "Stated s group home] on 4-2 -(Staff #2) "Stated s room with the indiv 6:30 am." -(Staff #2) "Stated s profanity but he was -(Staff #2) "Stated t stop it or he would of bedroom." -(Staff #2) "Stated t stop it or he would of bedroom."	oth staff followed and one of separate the individuals. Ogram supervisor and 911 es) in order to have [FC A] ole head injury. The police and Medical Services) came to the olice spoke to the individuals thappened. [FC A] refused to e to the ER (Emergency ram Supervisor took him to els] vitals were found to be and after the ER doctor and after the ER doctor all that was found was a corearm. [FC A] was released ome".						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G353		l í	JILDING	<u>00</u>	COMPL 06/08/	ETED	
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
REM OC	CAZIO LLC				SON, IN 46012		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	intervene but [FC A the med. room and [-(Staff #2) "Stated ti	he (staff #2) tried to] ran down the hallway past client A] chased him." that the other staff, [staff #3], ing down the hallway and					
	came out of the med happening."	l. room to see what was					
	-(Staff #2) "Stated to and [FC A] hit his h	hat [client A] pushed [FC A] ead on the ground."					
	-(Staff #2) "Stated that [client A] stomped on [FC A's] head two times before [staff #3] was able to separate the individuals".						
	-"Individual Intervi	ewed: [Staff #3], DSP".					
	-(Staff #3) "Stated s group home] on 4-2	he was working at [name of 3-21."					
	-(Staff #3) "Stated v office at 6:30 am."	vas passing med's in the staff					
		he saw [FC A] running down med. room and that [client A]					
		he got up to see what was she saw [client A] catch up to n to the ground."					
		hat [client A] stomped on [FC before she was able to get ne individuals."					
	-(Staff #3) "Stated [floor when he fell"	FC A] hit his head on the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15G353	B. W	ING		06/08/	2021
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	2		1	ARKWAY DR		
REM OCCAZIO LLC					SON, IN 46012		
					3014, 114 40012		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	-"Individual Intervi	ewed: [Client A], Individual".					
		he was at [name of group					
	home] on 4-23-21."						
		he was laying on the couch					
	making noises."						
	-(Client A) "Stated	[FC A] tried to hit him."					
	(61)						
		he ran after [FC A], threw him					
		omped on [FC A's] face with					
	his foot."						
	(51)						
	-(Client A) "Stated	he didn't have shoes on."					
	(C1: 4 A) IIG4 4 1	41 4 5 4 66 1123 11 4					
		that [staff #3] saw what					
	happened and calmo	ed nim down."					
	(Client A) "Stated	that [staff #2] was in the staff					
	office passing med's	that [staff #3] was in the staff					
	office passing med	S.					
	-(Client A) "Stated	he threw [FC A] down and					
		cause he (client A) felt rage					
	1 ^	A] had done to him in the					
	past."	A] had done to him in the					
	Pasi.						
	-(Client A) "Stated	he was angry from things [FC					
		before. (Past peer to peer					
	incidents)".	concret (a mon poor to poor					
	, ·						
	A review of the BD	DS report and Individual					
		as dated 4/25/21 and 4/23/21					
	indicated client A p	ushed FC A down to the floor					
		the face. The review did not					
	indicate documenta	tion of a thorough					
		eview did not indicate					
	~	or effective corrective					
		t further incidents of client to					
	client aggression.						

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	(X2) MULTIPLE C A. BUILDING B. WING	OONSTRUCTION OO	(X3) DATE COMPI 06/08	LETED
	PROVIDER OR SUPPLIER		1012 F	CADDRESS, CITY, STATE, ZIP COE PARKWAY DR RSON, IN 46012	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	On 5-11-21 IN (Ind complaint regarding [client A]. The com was being physicall The complainant all and hit [client A]. The urinated in [client A] were roommates) can complainant express of [FC A's] televisic complainant also in touched [client A] in were separated from 5-11-21 with [FC A possible placement living) services were agreed to peruse (si appropriate fit for [Indicated the facility alleging FC A was alleging FC A was alleging FC A was alleging allegation in the properties of the prop	dicated that [FC A] had nappropriately The two men n rooming together on 's] guardian to discuss other options; waiver (supported e discussed and the guardian c) as that might be a more				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	l í	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 06/08 /	ETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤΕ	(X5) COMPLETION DATE
	APS referenced that of an incident in whaggressive toward[of C's] face IDT met guardian to discuss due to the APS cone the two men. Guard exploring a different the waiver process of Documents to start provided by IN Met 5-12-21. On 5-13-2 (sic) another group the home would be LOC (Level of Care for [FC A] on an en 5-13-21. Transition with guardian, Men Staff training for [Fhome is being comp will move into his real and the facility regarding allegation towards client C. The documentation of a review indicated FC home on 5/14/21. FC A was no longer and was not able to Client A was asked Client A stated, "Ye A was asked if FC A clients. Client A stated."	C A] residing in the home. It his mother informed them hich [FC A] was physically blient C] and scratched [client on 5/12/21 with [FC A's] potential placement options cerns in the home between ian for [FC A] was open to t group home option while was being completed. The waiver process were not to BDDS for [FC A] on 1 [FC A's] guardians toured home option and agreed that a good fit for [FC A]. The expect was completed by BDDS hergency basis and approved meeting was (sic) completed tor and BDDS on 5-13-21. C A] with the staff at the new bleted on 5-14-21. [FC A] hew home on 5-14-21." DS report dated 5/12/21 by received a complaint is of physical abuse by FC A her review did not indicate thorough investigation. The C A was moved to a new group of a resident at the group home be interviewed. The complete the group home be interviewed.					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO UILDING	00	(X3) DATE COMPL		
		15G353	B. W	ING		06/08/	/2021
NAME OF	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE	•	
REM OC	CAZIO LLC				SON, IN 46012		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	sustained injuries as aggression by FC A C] had a scar on his scratches on [client asked if he was afra "Probably just nerve someone again." Client D was interve Client D was asked Client D stated, "No stern voice he woul everyday since he gif FC A had hit any stated, "I've heard he seen it." Client B was interve Client B was asked by FC A. Client B stime he scratched [client G was asked Client G was asked Client G was asked Client G stated, "Ye time. After that he was messing with me." (hit any of the other couple of times. He good. Pretty much a had to defend thems) Client C was interve Client C was asked stated, "Yes." Staff #4 was interving Staff #4 was asked st	s a result of physical Client A stated, "Yes, [client head and there were H's] face." Client A was aid of FC A. Client A stated, ous that he would attack liewed on 6/2/21 at 7:05 AM. If FC A had ever hit him. If he threatened me. If I used a d stop. He was doing that to here." Client D was asked of the other clients. Client D e hit the other guys but I never liewed on 6/2/21 at 7:29 AM. If client C had ever been hurt stated, "Yes, I seen him one client C's] face. It was pretty liewed on 6/2/21 at 7:39 AM. If FC A had ever hit him. If FC A had ever hit him him hit him					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	(X2) MULTIPLE A. BUILDING B. WING	OONSTRUCTION 00	(X3) DATE COMPI 06/08	LETED
	PROVIDER OR SUPPLIER		1012	ET ADDRESS, CITY, STATE, ZIP COI PARKWAY DR ERSON, IN 46012	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APF DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	of a list of things. Halong with everybody." Staff aggressive towards stated, "Yes he wound staff #5 was interving Staff #5 was asked of the other clients. Was pretty consister if she had seen FC #5 stated, "I saw the one of them was pretty consister if she had seen FC #5 stated, "I saw the one of them was pretty consister if she had seen FC #5 stated, "I saw the one of them was pretty consister if she had seen FC #5 stated, "I saw the one of them was going HD. Client H was see asked how often FC towards his housem happened several time when he was going RD (Regional Direct 6/2/21 at 2:00 PM. I was moved out of the RD #1 stated, "Becaphysical aggression that requested he may because [client A's] concern and request any longer." RD #1 not provide document thorough investigating client to client aggrey physical abuse by Fregarding allegation in inappropriate touch RD #1 indicated the prevention of abuse should be implement.	im not being able to get dy. Kind of like for the safety f #4 was asked FC A was the other clients. Staff #4 ld slap, he would punch." ewed on 6/2/21 at 8:08 AM. if she had seen FC A hit any Staff #5 stated, "I did. He at with it." Staff #5 was asked A scratch client C's face. Staff e aftermath of it. I remember etty deep. But it was [client ratched up bad." Staff #5 was A would physically aggress ates. Staff #5 stated, "It mes a week. They never knew to do something." ettor) #1 was interviewed on RD #1 was asked why FC A me group home on 5/14/21. huse of the increase in and we had family members eve." RD #1 was asked why at of the room with client A. separated the two of them grandmother called in a led they not room together indicated the facility could matation of any complete, lons regarding incidents of lession, allegations of C A towards client C or as of physical abuse and ling by FC A towards client A.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ILTIPLE COI ILDING	NSTRUCTION 00	(X3) DATE : COMPL		
		15G353	B. WI	NG		06/08/	2021
	PROVIDER OR SUPPLIER			1012 PA	DDRESS, CITY, STATE, ZIP CODE ARKWAY DR SON, IN 46012		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
		the reported immediately to d to BDDS within 24 hours.					
	reviewed on 6/4/21 Quality and Risk M	's and procedures were at 10:00 AM. The facility's anagement Policy dated licated the following:					
	service and seeks to Indiana Mentor serv management procec operations, close me and through a proce	romotes a high quality of protect individuals receiving vices through oversight of dures and company onitoring of service delivery ss of identifying, evaluating which individuals are					
	Reporting policy as Standards. An incid	ollows the BDDS Incident outlined in the Provider ent described as follows shall DDS on the incident report the BDDS."					
	exploitation of an ir category shall also be	ed or actual abuse, neglect, or idividual. An incident in this be reported to Adult of Child Protective Services					
	e. Failure to provide care or training;"	e appropriate supervision,					
	This federal tag rela#IN00353635.	tes to complaint					
	9-3-2(a)						
W 0153 Bldg. 00	483.420(d)(2) STAFF TREATME The facility must e	ENT OF CLIENTS nsure that all allegations of					

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE	DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15G353	B. W	B. WING 06/08/20			/2021
				CTREET	ADDRESS SITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE		
551100	0.4710.11.0				ARKWAY DR		
REM OC	CAZIO LLC			ANDER	RSON, IN 46012		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	·	DATE
	mistreatment, neg	lect or abuse, as well as					
	injuries of unknow	n source, are reported					
immediately to the administrator or to other							
	officials in accorda	ance with State law through					
	established proce	dures.					
	Based on record rev	view and interview for 3 of 20	W ()153			07/08/2021
	allegations of abuse	e, neglect and mistreatment			1. What corrective action v	will	
	reviewed, the facilit	ty failed to report incidents of			be accomplished?		
	client to client aggre	ession regarding FC (Former			 Training will be complete 	:d	
	Client) A towards c	lients A, C and E to BDDS			with the Program Director		
		mental Disabilities Services)			regarding:		
	within 24 hours of l	knowledge.			o Abuse, neglect and exploit	ation	
				policy			
	Findings include:				o Incident reporting expectat	ions	
	•	S reports and investigations			2. How will we identify oth		
	were reviewed on 6	/2/21 at 9:26 AM.			residents having the potential	al	
					to be affected by the same		
	-	lated 1/29/21 indicated on			deficient practice and what		
		eported that while in the			corrective action will be take	n?	
		of the individuals, [FC A]			· All residents have the		
	_	hysically aggressive. [Client			potential to be affected by the		
		front of [FC A] and [FC A]			same deficient practice.		
		Client C] saw this and hit [FC			· Training will be complete	d	
	_	recting all 3 individuals and			with the Program Director		
		C A] began being verbally			regarding:	_4:	
		ing at [client C]. [Client C] hit			o Abuse, neglect and exploit	สแดก	
		hit him back, then [FC A] left			policy	iono	
	_	C] followed him (FC A) out ooth individuals continued			o Incident reporting expectat	10115	
					3. What measures will be		
		Staff prompted them to stop I verbal prompt, they			put into place or what system		
		able to be redirected. Staff			changes will be made to ens		
	_	idual for injuries and none			that the deficient practice do		
					not recur:		
	were found IDT meets weekly to discuss [FC A's] behavior and meets to discuss [client E] and				· Training will be complete	·d	
	[client C] when nee	-			with the Program Director	~	
	Lanent of when hee				regarding:		
	-A review of the RI	DDS report dated 1/29/21			o Abuse, neglect and exploit	ation	
	indicated an incider	-			policy		
	and moraci		1		[,		I

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED	
		15G353	B. W	ING		06/08/2021	
				CTREET	ADDRESS SITY STATE ZID CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
	a.=.aa				ARKWAY DR		
REM OC	CAZIO LLC			ANDER	RSON, IN 46012		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	aggression occurred	d between FC A and clients C			o Incident reporting expectati	ons	
	and E. The review of	did not indicate the facility					
	reported the incider	nt of client to client			4. How will the corrective		
	aggression occurred	d between FC A and clients C			action be monitored to ensur	re	
	and E to BDDS wit	hin 24 hours of knowledge.			the deficient practice will not	:	
					recur?		
	2. A BDDS report of	dated 3/18/21 indicated on			The Quality Improvement	t	
	3/15/21, " [Client	A] was walking out of his			Department and the Area Dire	ctor	
	bedroom and was w	valking into the bedroom after			will monitor incidents as they a	are	
	being prompted by	the Program Supervisor to			reported to ensure that they ar	re	
	take a shower. [FC	A] hit [client A] in the back.			reported timely and that all		
	The program super	visor redirected [FC A] and			required incidents are reported	d to	
	had him apologize	to [client A]. The program			BDDS.		
	supervisor checked	[client A] for injuries and		· The Program Supervisor			
	found none. The pro-	ogram supervisor checked			and Program Director will revie	ew	
		es and found none. The		progress notes two times weekly			
		asked [client A] if he was		for 4 weeks to be sure there are			
	okay and he laughe	d and left the room".			not any incidents noted by the		
					direct support staff that were n		
		DDS report dated 3/18/21			reported per the BDDS reporti	ng	
	indicated an incider				policy. On-going the Program		
		d between FC A and client A.			Supervisor will review progres		
		indicate the facility reported			notes weekly for completeness	S	
		nt to client aggression			and content.		
		C A and client A to BDDS			Oversight of the behavior	I	
	within 24 hours of l	knowledge.			documentation will be complet	ed	
					by the Program Coordinator,		
	-	dated 3/21/21 indicated on			QIDP, Behavior Clinician.		
	_	A] reported to staff that			The Behavior Clinician w	III	
		oom [FC A] pushed him onto			monitor during their monthly		
		Client A] told staff that [FC A]			observations.		
		lient A's] pants down. [Client			Former Client A has been	1	
		ed his pants back up and came			moved to a new home and is	:	
		eident to staff. Staff checked			currently looking at placement	ın	
		es and made sure that he was			Waiver setting.		
	okay. No injuries were found. Staff spoke with						
		utting his hands on or being	_		E Milest in the data becaute		
		other individuals IDT			5. What is the date by which		
		eam) team meet weekly to			the systemic changes will be		
1	ascuss [FC A's] be	havior and meets to discuss			completed?		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G353		(X2) MULTII A. BUILDII B. WING		nstruction <u>00</u>	(X3) DATE : COMPL 06/08/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	[client A] when nee			_	July 8th, 2021			
	-A PPAQ (Peer to F form dated 3/18/21 (Program Supervisor following: -"Please describe w incident in detail be -"[Client A] came a pushed him on the bear was out and he (clie tried to pull down he pulled his pants at then went to tell state underwear down' [ceep with the could have prevent a future inceep with the pulled his pants at the	Peer Aggression Questions) and completed by PS or) #1 indicated the that was observed during the low:" and told staff that [FC A] bed where his butt (buttock) and A) was facing the wall and is pants. He (client A) said ap and came out in the hallway and the didn't get to pull my lient A] said". been done differently to			July 8th, 2021			
	6/2/21 at 2:00 PM. was moved out of the RD #1 stated, "Becar physical aggression that requested he m FC A was moved on	etor) #1 was interviewed on RD #1 was asked why FC A me group home on 5/14/21. The ause of the increase in and we had family members ove." RD #1 was asked why cut of the room with client A. Separated the two of them						

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			î ′		` <i>'</i>	(3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G353		<u> </u>		06/08/	
		100000		CTDEET /	ADDRESS, CITY, STATE, ZIP CODE	00/00/	2021
NAME OF I	PROVIDER OR SUPPLIE	R			ARKWAY DR		
REM OC	CAZIO LLC		ANDERSON, IN 46012				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
W 0154 Bldg. 00	because [client A's] concern and reques any longer." RD # abuse, neglect and reported immediate BDDS within 24 hd. This federal tag relations are also as a second record	grandmother called in a sted they not room together 1 indicated all allegations of mistreatment should be ely to the administrator and to purs. ENT OF CLIENTS nave evidence that all are thoroughly investigated. Eview and interview for 11 of puse, neglect and wed, the facility failed to gate several incidents of client are garding FC A towards and H, allegations of physical an allegation of inappropriate garding FC A towards client A. S (Bureau of Developmental es) reports and investigations	W	0154	1. What corrective action vibe accomplished? Training will be complete with the Program Director regarding: o Investigation expectations o Components of a thorough investigation 2. 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. Training will be complete with the Program Director regarding: o Investigation expectations o Components of a thorough investigation	er al n?	07/08/2021

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. B	A. BUILDING <u>00</u>		COMPLETED	
		15G353	B. W	ING		06/08/2021	
				CTREET	ADDRESS SITY STATE ZID CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP CODE		
					ARKWAY DR		
REM OC	CAZIO LLC			ANDER	RSON, IN 46012		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROVIDERIC DI AM OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	bit [client C] on the	arm. [Client C] scratched [FC			3. What measures will be		
A] on the hand. The Program Supervisor was able				put into place or what system	nic		
	_	ividuals. Both individuals			changes will be made to ens		
	_	juries. [Client C] had a red			that the deficient practice do		
		d [FC A] had a minor scratch			not recur:		
		was washed. Both individuals			Training will be complete	ed l	
	· ·	o other activities. [Client C]			with the Program Director		
		hone and [FC A] was walking			regarding:		
		when he saw [client G] standing			o Investigation expectations		
	-	FC A] walked up to [client G]			o Components of a thorough		
	-	houlder. [Client G] did not			investigation		
	-	am supervisor stated that this			anvocagaach		
	, ,	our housemates and [FC A]			4. How will the corrective		
		at G]. [Client G] was checked			action be monitored to ensur		
	for injuries and non				the deficient practice will not		
	101 injuries and non	e were round.			recur?	,	
	-A review of the RI	DDS report dated 1/15/21			The Quality Improvemen	<u>, </u>	
		client C and pushed client G.			Department and the Area Dire		
		indicate documentation of an			will monitor incidents as they a		
		ling the client to client			reported to ensure that they a		
		towards clients C and G.			reported timely and that all	~	
	uggression by 1 c 71	towards elicitis & and G.			required incidents are reported	d to	
	2 A RDDS report of	lated 1/20/21 indicated on			BDDS.		
	-	and [client E] were eating			· Area Director and/or Qua	ality	
		of the individuals on the			Assurance will review	iiity	
		. Staff reported that [FC A]			investigations for thoroughnes	:0	
	was not sharing the				· All abuse and neglect	·	
	_	E] asked [FC A] to please			investigations will be reviewed	l by	
	_	a. [FC A] refused to share the			the Quality Improvement Spec	-	
	•	E]. Staff intervened and [FC			or her designee to ensure the	, and	
	_	eminded [FC A] that we do not			investigations are thorough.		
		her individuals. Staff asked			· All investigations that are	not	
	-	hands to himself. Staff			considered abuse and neglect		
		or injuries, a red mark was			be reviewed by the Area Direct		
	found, but later fade				or her designee to ensure the	,tO1	
	· ·	eam) meets weekly to discuss			investigations are thorough		
	` .	nd meets to discuss [client E]			Former Client A has been	n	
	when needed".	na meets to discuss [chefit E]			moved to a new home and is	· i	
	when heeded					in	
	A Cd DI	DDC 1-4- 1 1/20/21			currently looking at placement	. 111	
	-A review of the BI	ODS report dated 1/20/21			Waiver setting.		

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	F CORRECTION	IDENTIFICATION NUMBER:	ΔRI	JILDING	00	(X3) DATE SURVEY COMPLETED		
	1 CORRECTION	15G353	B. WI		00	06/08/		
		10000		CTDEET A	ADDRESS CITY STATE ZID CODE	00/00/	2021	_
NAME OF PR	OVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ARKWAY DR			
REM OCC	CAZIO LLC				SON, IN 46012			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID			(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE	
	indicated an inciden							
I .					<u> </u>			
1					_	,		
I .	client aggression.	ang una maraam ar anam ta			July 8th, 2021			
	-							
I .		•						
		= = =						
	_	front of [FC A] and [FC A]						
		Client C] saw this and hit [FC						
	_	_						
		C] followed him (FC A) out						
		oth individuals continued						
	-							
	-							
	were found IDT m	neets weekly to discuss [FC						
	_							
	[client C] when need	ded".						
	-A review of the BD	DDS report dated 1/29/21						
	indicated an inciden	•						
		between FC A and clients C						
	The to onone aggre							
		ated 3/11/21 indicated on						
I .								
		C A] raised his hand as if he						
	-	m (staff). [Client H] saw this						
PREFIX TAG	indicated an incident aggression occurred. The review did not it investigation regards client aggression. 3. A BDDS report d. 1/25/21, " Staff reskitchen with some of started to become ple it investigation in pushed [client E]. [Condition of the kitchen. [Client Condition of the kitchen. [Client Condition of the kitchen and be hitting each other. Some and after the second separated and were acchecked each individual were found IDT may also behavior and may also behavior and may also behavior and may be a condition of the kitchen and behavior and may be a condition of the kitchen and behavior and may be a condition of the kitchen and behavior and may be a condition of the behavior and may be a condition of the BD indicated an incident aggression occurred and E. The review do fan investigation reclient to client aggression occurred and E. The review do fan investigation reclient to client aggression occurred and E. The review do fan investigation reclient to client aggression asked [FC A] to take [FC A] started becomes a shower. [FC A] started becomes a shower. [FC A] to take [FC A] started becomes a shower. [FC A] asked [FC A] to take [FC A] started becomes a shower. [FC A] taken [FC A] asked [FC A] to take [FC A] started becomes a shower. [FC A] taken [FC A] asked [FC A] to taken [FC A] asked [FC A] asked [FC A] to taken [FC A] asked [FC A] asked [FC A] to taken [FC A] asked [FC A] asked [FC A] to taken [FC A] asked [FC A] asked [FC A] asked [FC A] to taken [FC A] asked	to f client to client between FC A and client E. ndicate documentation of an ing this incident of client to ated 1/29/21 indicated on ported that while in the f the individuals, [FC A] nysically aggressive. [Client front of [FC A] and [FC A] Client C] saw this and hit [FC ecting all 3 individuals and E A] began being verbally ng at [client C]. [Client C] hit hit him back, then [FC A] left C] followed him (FC A) out oth individuals continued taff prompted them to stop verbal prompt, they able to be redirected. Staff dual for injuries and none neets weekly to discuss [FC eets to discuss [client E] and ded". DDS report dated 1/29/21 to of client to client between FC A and clients C id not indicate documentation egarding this incident of easion. ated 3/11/21 indicated on ff and the program supervisor e a shower and he refused. ming verbally aggressive and o get out and that he was not E A] raised his hand as if he		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) 5. What is the date by which the systemic changes will be completed?	:h	COMPLETI	ON

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	OF CORRECTION	IDENTIFICATION NUMBER: 15G353	A. BUILDING B. WING	<u>00</u>	COMPLETED 06/08/2021
	PROVIDER OR SUPPLIER		1012 F	ADDRESS, CITY, STATE, ZIP CODE PARKWAY DR RSON, IN 46012	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	hitting staff and [FC H] started hitting [F scratching [client H] H] and ripped his sh tried to separate the them to stop fighting prompted the individuals separate program supervisor injuries. [Client H] I forehead and nose a A] had a small scrat individuals were cle ointment was put on continue to treat ind aid IDT (Interdisc weekly to discuss [F discuss [client E] w -A PPAQ (Peer to P form dated 3/9/21 at (Program Superviso following: -"Please describe whincident in detail be "FC A] was asked [PS #1]." -" [FC A] told staff A) started acting lik [client H] intervene [client H]. [Client H started fighting. [Clifloor and kept hittin [client H] off of [FC III] was a short program of the started fighting. [Clifloor and kept hittin [client H] off of [FC III] was a short program of the started fighting. [Clifloor and kept hittin [client H] off of [FC IIII] was a short program of the started fighting. [Clifloor and kept hittin [client H] off of [FC IIII] was a short program of the started fighting. [Clifloor and kept hittin [client H] off of [FC IIIII] was a short program of the started fighting. [Clifloor and kept hittin [client H] off of [FC IIIII] was a short program of the started fighting. [Clifloor and kept hittin [client H] off of [FC IIIIIIIII] was a short program of the started fighting. [Clifloor and kept hittin [client H] off of [FC IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	eer Aggression Questions) and completed by PS r) #1 indicated the			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G353		A. BUILDIN B. WING	G <u>00</u>	ON	COMPL 06/08/	ETED	
	PROVIDER OR SUPPLIER		10 ⁻	EET ADDRESS, O 2 PARKWAY DERSON, IN			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAC	X (EACH CROSS-R	ROVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	(Client H's] nose are						
	-"What could have been done differently to prevent a future incident?"						
	-"(PS #1) Nothing, [FC A] needs to stop spitting on others."						
	indicated FC A beca him to take a showe FC A threatened to in an attempt to prot	AQ form dated 3/9/21 Ime upset when staff asked In The review indicated when Initiating the staff, client H "intervened" Initiating the staff. The review Initiating the staff asked In					
	a result of the incide aggression on 3/9/22	ent of client to client I. The review did not indicate ion of an investigation					
	3/15/21, " [Client bedroom and was w being prompted by t	ated 3/18/21 indicated on A] was walking out of his alking into the bedroom after he Program Supervisor to A] hit [client A] in the back.					
	had him apologize to supervisor checked found none. The pro-	isor redirected [FC A] and o [client A]. The program [client A] for injuries and ogram supervisor checked and found none. The					
	program supervisor	asked [client A] if he was and left the room".					
	indicated an inciden aggression occurred The review did not i investigation regard	DS report dated 3/18/21 t of client to client between FC A and client A. ndicate documentation of an ing this incident of client to ne review did not indicate					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G353		A. BUILDING B. WING	COMPLETED 06/08/2021		
	PROVIDER OR SUPPLIER		1012 F	ADDRESS, CITY, STATE, ZIP CODE PARKWAY DR RSON, IN 46012	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) or effective corrective	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	client aggression.	further incidents of client to ated 3/21/21 indicated on			
	3/18/21, " [Client while in their bedroothe bed face first. [C attempted to pull [cl	A] reported to staff that om [FC A] pushed him onto client A] told staff that [FC A] ient A's] pants down. [Client			
	and reported the inc [client A] for injuries okay. No injuries we	In the staff of th			
	aggressive towards other individuals IDT (Interdisciplinary Team) team meet weekly to discuss [FC A's] behavior and meets to discuss [client A] when needed".				
		eer Aggression Questions) and completed by PS r) #1 indicated the			
	-"Please describe which incident in detail be	hat was observed during the low:"			
	pushed him on the b was out and he (clie tried to pull down h he pulled his pants t	nd told staff that [FC A] wed where his butt (buttock) nt A) was facing the wall and is pants. He (client A) said up and came out in the hallway ff. 'He didn't get to pull my lient A] said".			
	prevent a future inci				
	-"Nothing except fo on [FC A]."	r trying to keep a better eye			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUI A. BUII		NSTRUCTION 00	(X3) DATE : COMPL		
		15G353	B. WIN	G		06/08/	2021
	PROVIDER OR SUPPLIER			1012 PA	DDRESS, CITY, STATE, ZIP CODE ARKWAY DR SON, IN 46012		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	indicated FC A pusi- attempted to pull do review did not indici investigation regard client aggression/se behavior. The revie documentation of ai incident of client to inappropriate behav 7. A BDDS report of 4/11/21, " [Client A] was messing wit when [client A told A]. [Client A] left to the event to staff. So injuries and made so injuries were found about not putting hi aggressive towards meet regularly to di meets to discuss [cl -A review of the BI indicated an incider aggression occurred The review did not investigation regard client aggression. 8. A BDDS report of On 4/18/21 [FC A] medical treatment w scratches and notifi guardian decided he to recent conversati A]. The Program So	lated 4/13/21 indicated on A] reported to staff that [FC h [client A's] smart TV and him to stop [FC A] hit [client he room and went to report taff checked [client A] for ure that he was okay. No a Staff spoke with [FC A] s hands on or being other individuals IDT team scuss [FC A's] behavior and ient A] when needed". DDS report dated 4/13/21					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		15G353	B. WING		06/08/2021	
			STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	CR.		PARKWAY DR		
REM OC	CAZIO LLC			RSON, IN 46012		
	•	OT A TEN CENT OF DEPICIENCIES		1	(1/5)	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	· ·	NCY MUST BE PRECEDED BY FULL B. L. S.C. IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI		
TAG		R LSC IDENTIFYING INFORMATION)	IAG	DEFICIENCE	DATE	
		suggested to the parents. The men did not want to have them				
	_	e to keep them separated. They				
	1 -	ld make them uncomfortable to				
		ironment. The team suggested				
		ic) evaluation for [FC A] due to				
		nd his (FC A's) guardian did				
		ded at the time. [Client C's]				
		up for the night The IDT has				
	•	guardian has agreed to let him				
		. Mentor will revise both				
	_	(Behavior Support Plan) and				
	meet biweekly for	[FC A]."				
	-A PPAQ form dat	ted 4/18/21 and completed by				
	PS (Program Supe	rvisor) #1 indicated the				
	following:					
		what was observed during the				
	incident in detail b	elow:"				
	HG. CC FG. CC #13	11 1 4 27 DM 4 4 11				
		alled me at 4:37 PM. to tell a living room and [client C] got				
		(Client C) to shut up. [FC A]				
	_	they got into a scuffle.				
		sic) scratched up. They were				
	`	ce were called by family				
	(Dad)."	to were cancally family				
	(=)					
	-"What could have	been done differently to				
	prevent a future in	-				
	-"(PS #1) [FC A] o	comes in the living room				
	messing with other	r peers often."				
	-	ed 4/18/21 and completed by				
	staff #1 indicated t	the following:				
		what was observed during the				
	incident in detail b	elow:"				
	I .			1		

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Facility ID: 000869

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BU	JILDING	00	(X3) DATE COMPL		
		15G353	B. W	ING		06/08/	2021
	PROVIDER OR SUPPLIER			1012 PA	.ddress, city, state, zip code ARKWAY DR SON, IN 46012		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	A] to leave me alon to 'shut the [expletiv [expletive] hit you.' [Client C] blocked to	aff (Me). [Client C] told [FC e. [FC A] told him (client C] we] up or I'm going to [FC A] went to hit [client C]. the hit [FC A] scratched (sic). The fight was able to be					
	-"(Staff #1) [Client C] scratches on his face. First Aid was done (sic)."						
	-"What could have been done differently to prevent a future incident?"						
	-"Keep them apart.'	,					
	incident of client to FC A and client C creview indicated cli his face. The review asked for the Police C's injuries. The rev	AQ forms indicated an client aggression between occurred on 4/18/21. The ent C sustained scratches to a indicated client C's father to be called to report client view did not indicate thorough investigation.					
	4/23/21," While in room waiting on tra Services, [FC A] be said a curse word. [at [FC A], but [FC (FC A) would escon A] went over to [cli and [client A] grabb back. Staff came ov individuals to separ	lated 4/25/21 indicated on andividuals were in the living insport to take them to Day became upset when [client A]. Client A] was not curing (sic). A] told [client A] to stop or he at [client A] to his room. [FC ent A] and reached out to him bed [FC A] and bent his fingers are and prompted the ate and [FC A] then turned and and [Client A] chased [FC A].					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G353		A. BUILDING B. WING	<u>00</u>	COMPLETED 06/08/2021	
	PROVIDER OR SUPPLIER		1012	r address, city, state, zip code PARKWAY DR ERSON, IN 46012	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	on [FC A's] head. B the staff was able to Staff called their pro (Emergency Service evaluated for possib EMS (Emergency M group home. The po and staff about what go in the ambulance Room), so the Progr be evaluated. [FC A within normal limits assessed him (FC A scratch to the right f back to the group ho Individual Interview indicated the follow -"Individual Interview indicated the follow -"Individual Interview indicated the follow -"Staff #2) "Stated s group home] on 4-2 -(Staff #2) "Stated s room with the indiv 6:30 am." -(Staff #2) "Stated s profanity but he was -(Staff #2) "Stated ti stop it or he would of bedroom." -(Staff #2) "Stated ti client A] and reach	r forms dated 4/23/21 ing: ewed: [Staff #2], DSP (Direct 1)			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO UILDING	00	(X3) DATE COMPL		
		15G353	B. W	ING		06/08/	2021
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
REM OC	CAZIO LLC				ARKWAY DR SON, IN 46012		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION
TAG	REGULATORY OR back."	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	-(Staff #2) "Stated s intervene but [FC A the med. room and -(Staff #2) "Stated t saw both guys runn came out of the med happening."	the (staff #2) tried to a] ran down the hallway past [client A] chased him." that the other staff, [staff #3], sing down the hallway and al. room to see what was that [client A] pushed [FC A]					
	-(Staff #2) Stated that [client A] pushed [FC A] and [FC A] hit his head on the ground." -(Staff #2) "Stated that [client A] stomped on [FC A's] head two times before [staff #3] was able to separate the individuals".						
	-"Individual Intervi	ewed: [Staff #3], DSP".					
	-(Staff #3) "Stated s group home] on 4-2	the was working at [name of 3-21."					
	-(Staff #3) "Stated v office at 6:30 am."	was passing med's in the staff					
		the saw [FC A] running down med. room and that [client A]					
		the got up to see what was she saw [client A] catch up to m to the ground."					
		hat [client A] stomped on [FC before she was able to get he individuals."					
	-(Staff #3) "Stated [floor when he fell	FC A] hit his head on the ".					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G353		(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMPI 06/08	LETED			
	PROVIDER OR SUPPLIEF	2	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	D BE	(X5) COMPLETION DATE		
	-"Individual Intervi	ewed: [Client A], Individual".						
	-(Client A) "Stated home] on 4-23-21."	he was at [name of group						
	-(Client A) "Stated making noises."	he was laying on the couch						
	-(Client A) "Stated	[FC A] tried to hit him."						
		he ran after [FC A], threw him omped on [FC A's] face with						
	-(Client A) "Stated	he didn't have shoes on."						
	-(Client A) "Stated happened and calme	that [staff #3] saw what ed him down."						
	-(Client A) "Stated office passing med'	that [staff #3] was in the staff s."						
	-(Client A) "Stated he threw [FC A] down and stomped on him because he (client A) felt rage from stuff that [FC A] had done to him in the past."							
		he was angry from things [FC before. (Past peer to peer						
	Interview statement indicated client A p	DDS report and Individual ts dated 4/25/21 and 4/23/21 sushed FC A down to the floor the face. The review did not tion of a thorough						
	10. A BDDS report	dated 5/12/21 indicated, "						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G353		A. BU	A. BUILDING 00 B. WING			ETED 2021	
	PROVIDER OR SUPPLIER CAZIO LLC			1012 PA	ddress, city, state, zip code ARKWAY DR SON, IN 46012		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	complaint regarding [client A]. The compwas being physically The complainant all and hit [client A]. Turinated in [client A] were roommates) care complainant express of [FC A's] televisite complainant also into touched [client A] in were separated from 5-11-21 with [FC A possible placement living) services were agreed to peruse (sie appropriate fit for [IFF]. A review of the BE indicated the facility alleging FC A was perused to the services of the services in the review indicate complaint alleging I in the review indicate complaint alleging I in the review indicate the facility alleging allegation in the review indicate complaint alleging I in the review FC A out of client A. The rev	dicated that [FC A] had nappropriately The two men a rooming together on 's] guardian to discuss other options; waiver (supported be discussed and the guardian be) as that might be a more					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO JILDING	NSTRUCTION 00	(X3) DATE COMPL		
		15G353	B. W	ING		06/08/	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER				ARKWAY DR		
REM OC	CAZIO LLC				SON, IN 46012		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		client C] and scratched [client					
		on 5/12/21 with [FC A's]					
	_	potential placement options					
		cerns in the home between					
		lian for [FC A] was open to					
		t group home option while					
	the waiver process	was being completed.					
	Documents to start	the waiver process were					
		ntor to BDDS for [FC A] on					
		1 [FC A's] guardians toured					
		home option and agreed that					
		a good fit for [FC A]. The					
	`	e) was completed by BDDS					
		nergency basis and approved					
		meeting was (sic) completed tor and BDDS on 5-13-21.					
	_	C A] with the staff at the new					
		pleted on 5-14-21. [FC A]					
		new home on 5-14-21."					
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
	A review of the BD	DS report dated 5/12/21					
		y received a complaint					
	regarding allegation	ns of physical abuse by FC A					
	towards client C. Tl	ne review did not indicate					
	documentation of a	thorough investigation. The					
	review indicated FO	C A was moved to a new group					
	home on 5/14/21.						
	FC A was no longer	r a resident at the group home					
	and was not able to						
	Client A was intomy	iewed on 6/2/21 at 6:54 AM.					
		if FC A had ever hit him.					
		es, like a lot of times." Client					
		A had hit any of the other					
		ted, "Yes, everybody but					
		was asked if any clients had					
		s a result of physical					
	1	Client A stated, "Yes, [client					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO UILDING	NSTRUCTION 00	(X3) DATE COMPL		
		15G353	B. W	ING		06/08/	2021
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>		DDRESS, CITY, STATE, ZIP CODE	•	
REM OC	CAZIO LLC			1	SON, IN 46012		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
IAU	C] had a scar on his scratches on [client asked if he was afra "Probably just nerve someone again." Client D was interved Client D stated, "No stern voice he woule everyday since he gif FC A had hit any stated, "I've heard he seen it." Client B was interved lient B was asked by FC A. Client B stime he scratched [client G was asked by FC As the seen it." Client G was interved lient G was asked client G stated, "Ye time. After that he was messing with me." If hit any of the other couple of times. He good. Pretty much a had to defend thems. Client C was interved lient C was asked stated, "Yes." Staff #4 was interved lient C was asked stated, "Yes."	head and there were H's] face." Client A was id of FC A. Client A stated, bus that he would attack fewed on 6/2/21 at 7:05 AM. if FC A had ever hit him. by, he threatened me. If I used a d stop. He was doing that of there." Client D was asked of the other clients. Client D e hit the other guys but I never fewed on 6/2/21 at 7:29 AM. if client C had ever been hurt tated, "Yes, I seen him one client C's] face. it was pretty fewed on 6/2/21 at 7:39 AM. if FC A had ever hit him. es, I had to defend myself one was afraid of me. He stopped Client G if he had seen FC A clients. Client G stated, "A scratched [client C] real all of the guys in the house selves from him." fewed on 6/2/21 at 7:52 AM. if FC A had hit him. Client C ewed on 6/2/21 at 6:37 AM. why FC A was no longer a b home. Staff #4 stated, "Kind firm not being able to get dy. Kind of like for the safety		TAG	DEPALENCY		DATE

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BU	JILDING	00	(X3) DATE COMPL			
		15G353	B. W	ING		06/08/	2021	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012					
	SUMMARY S' (EACH DEFICIEN REGULATORY OR of everybody." Staff aggressive towards stated, "Yes he wou Staff #5 was intervi Staff #5 was asked of the other clients. was pretty consister if she had seen FC A #5 stated, "I saw the one of them was pre H]. Client H was see asked how often FC towards his housem happened several ti when he was going RD (Regional Direct 6/2/21 at 2:00 PM. was moved out of th RD #1 stated, "Beca physical aggression that requested he m FC A was moved on RD #1 stated, "We because [client A's] concern and request any longer." RD #1 not provide docume	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) If #4 was asked FC A was the other clients. Staff #4 Ild slap, he would punch." ewed on 6/2/21 at 8:08 AM. If she had seen FC A hit any Staff #5 stated, "I did. He at with it." Staff #5 was asked A scratch client C's face. Staff the aftermath of it. I remember tetty deep. But it was [client ratched up bad." Staff #5 was A would physically aggress ates. Staff #5 stated, "It mes a week. They never knew		1012 PA	ARKWAY DR	TE.	(X5) COMPLETION DATE	
	client to client aggrephysical abuse by Fregarding allegation	ession, allegations of C A towards client C or as of physical abuse and aing by FC A towards client A.						

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G353		A. BUILDING 00 COM		COMPLI	TE SURVEY MPLETED (08/2021		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012				
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATIONS		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI TAG TAG		TE	(X5) COMPLETION
PREFIX TAG W 0157 Bldg. 00	483.420(d)(4) STAFF TREATME If the alleged viola corrective action r Based on record rev 20 allegations of ab mistreatment review implement effective prevent multiple ind aggression regardin E, G and H, allegati and an allegation of regarding FC A tow Findings include: The facility's BDDS Disabilities Service were reviewed on 6 1. A BDDS report of 1/13/21, " Staff re in the kitchen puttir individual in the gre bit [client C]. Staff individuals and the already there. [FC A [client C] was still to turn to use the phon bit [client C] on the A] on the hand. The to separate both ind were checked for in mark on his arm and	ENT OF CLIENTS ation is verified, appropriate must be taken. View and interview for 11 of use, neglect and ved, the facility failed to e corrective measures to cidents of client to client g FC A towards clients A, C, tions of physical abuse by FC A inappropriate sexual behavior vards client A.	WO	TAG	CROSS-REFERENCED TO THE APPROPRIA	vill I do to the eds d ds le e as ase n in	O7/08/2021
	finished using the p walking down the h standing by the from	o other activities. [Client C] hone and [FC A] was was hallway when he saw [client G] ht door. [FC A] walked up to hed on his shoulder. [Client G]			corrective action will be take All residents have the potential to be affected by the same deficient practice. The Program Director wil		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SUR	RVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETE	ED
		15G353	B. W	NG		06/08/20	21
				CED FIELD	ADDRESS OF A STATE OF CODE		
NAME OF P	PROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP CODE		
					ARKWAY DR		
REM OC	CAZIO LLC			ANDER	RSON, IN 46012		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROWING BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	C	OMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		DATE
	did not retaliate. Th	e program supervisor stated			home observations bi-weekly t	:0	
		we treat our housemates and			ensure staff are implementing	the	
	[FC A] apologized	to [client G]. [Client G] was			plans of clients, the client's ne		
		and none were found."			are being met and meal		
					observations.		
	-A review of the BI	DDS report dated 1/15/21			· Training will be complete	d	
		client C and pushed client G.			with the Program Director		
		indicate documentation of			regarding:		
	corrective actions re	egarding the client to client			a. Investigation expectations	s	
		towards clients C and G.			b. Components of a thoroug		
					investigation		
	2. A BDDS report of	lated 1/20/21 indicated on			The IDT will monitor trend	ds	
	1	and [client E] were eating			and patterns in client reportable	е	
		of the individuals on the			incidents. The IDT will conven-	e as	
	evening on 1/19/21.	Staff reported that [FC A]			necessary to discuss an increa	ase	
	was not sharing the				in reportable incidents.		
	individuals. [Client	E] asked [FC A] to please			· The QIDP will monitor an	d	
	pass the fruit to him	i. [FC A] refused to share the			review the resident's needs. A	s	
	fruit and hit [client]	E]. Staff intervened and [FC			the needs arise, formal		
	A] stopped. Staff re	minded [FC A] that we do not			programming will be implemer	ited.	
	put our hands on ot	her individuals. Staff asked			All client's risk plans and		
	[FC A] to keep his l	hands to himself. Staff			ISP's will be reviewed.		
	checked [client E] f	or injuries, a red mark was			· The Behavior Clinician w	ill	
	found, but later fade	ed away IDT			monitor during her monthly		
	(Interdisciplinary T	eam) meets weekly to discuss			observations.		
	[FC A's] behavior a	nd meets to discuss [client E]			· The nurse will monitor to		
	when needed".				ensure risk plans are being		
					followed during her observatio	ns	
	-A review of the BI	DDS report dated 1/20/21			when in the home.		
	indicated an incider	nt of client to client					
	aggression occurred	between FC A and client E.			1.What measures will be pu	ıt	
	The review did not	indicate documentation of			into place or what systemic		
	corrective actions re	egarding this incident of			changes will be made to ens	ure	
	client to client aggre	ession.			that the deficient practice do	es	
					not recur:		
	3. A BDDS report dated 1/29/21 indicated on				· The Program Director wil		
	1/25/21, " Staff reported that while in the				home observations bi-weekly t	ю	
	kitchen with some of the individuals, [FC A]				ensure staff are implementing	the	
	started to become p	hysically aggressive. [Client			plans of clients, the client's ne	eds	
	E] tried standing in	front of [FC A] and [FC A]			are being met and meal		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/C		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15G353	B. W	NG		06/08/	′2021
				CED FIELD	A DDDDGG CHTV CTATE TIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP CODE		
					ARKWAY DR		
REM OC	CAZIO LLC			ANDER	RSON, IN 46012		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROWIDER'S DLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	T-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	16	DATE
	pushed [client E]. [Client C] saw this and hit [FC			observations.		
	A] . Staff tried redirecting all 3 individuals and				· Training will be complete	d	
	separating them. [F	C A] began being verbally			with the Program Director		
	aggressive and yelli	ing at [client C]. [Client C] hit			regarding:		
	[FC A] and [FC A]	hit him back, then [FC A] left			a. Investigation expectation	s	
	the kitchen. [Client	C] followed him (FC A) out			b. Components of a thoroug	jh	
	of the kitchen and b	ooth individuals continued			investigation		
	hitting each other. S	Staff prompted them to stop			· The IDT will monitor trend	ds	
	and after the second	d verbal prompt, they			and patterns in client reportable	le	
	separated and were	able to be redirected. Staff			incidents. The IDT will conven-	e as	
	checked each indivi	idual for injuries and none			necessary to discuss an increa	ase	
	were found IDT n	neets weekly to discuss [FC			in reportable incidents.		
	A's] behavior and n	neets to discuss [client E] and			· The QIDP will monitor an	d	
	[client C] when nee	ded".			review the resident's needs. A	S	
					the needs arise, formal		
	-A review of the BI	DDS report dated 1/29/21			programming will be implemer	nted.	
	indicated an incider	nt of client to client			· All client's risk plans and		
	aggression occurred	l between FC A and clients C			ISP's will be reviewed.		
	and E. The review of	did not indicate documentation			· The Behavior Clinician w	ill	
	of of corrective act	ions regarding this incident			monitor during her monthly		
	of client to client ag	ggression.			observations.		
					· The nurse will monitor to		
		dated 3/11/21 indicated on			ensure risk plans are being		
	i i	ff and the program supervisor			followed during her observatio	ns	
		te a shower and he refused.			when in the home.		
		oming verbally aggressive and					
		to get out and that he was not			1.How will the corrective		
		C A] raised his hand as if he			action be monitored to ensur		
		em (staff). [Client H] saw this			the deficient practice will not	İ	
	1	he tried stopping [FC A] from			recur?		
		C A] spit on [client H]. [Client			· The Behavior Clinician w		
		FC A] and [FC A] started			monitor as they is in the home	for	
	scratching [client H]. [FC A] tried biting [client				her monthly observations.		
	H] and ripped his shirt. The program supervisor				The Program Director wil		
	tried to separate the individuals and prompted				monitor when they is in the ho	me	
	them to stop fighting. The program supervisor				to complete their supervisory		
	prompted the individuals to stop fighting again.				visits.		
		hitting [FC A] and the			The Program Coordinato		
	_	ed and were redirected. The			will monitor on a daily basis wi	nen	
	program supervisor	checked both individuals for			she is in the home.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15G353	B. W	ING		06/08/	2021
				CTREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIE	R					
DEMOC	CA710 LLC				ARKWAY DR		
REM OC	CAZIO LLC			ANDER	RSON, IN 46012		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		had small scratches on his			· The Program Director wil		
	forehead and nose as well as his upper chest. [FC				home observations bi-weekly		
	A] had a small scratch on his leg and hand. Both				ensure staff are implementing		
	individuals were cleaned up and antibiotic				plans of clients, the client's ne	eds	
	ointment was put o	n their scratches Staff to			are being met and meal		
		dividuals' scratches with first			observations.		
	· ·	ciplinary Team) team meet			 New staff hired to work a 		
	-	FC A's] behavior and meets to			the site will receive client spec	cific	
	discuss [client E] v	when needed".			training for each individual price	or to	
					working a shift. This training		
		Peer Aggression Questions)			includes items such as: client's	S	
		and completed by PS			diets, risk plans, ISP's,		
	(Program Supervise	or) #1 indicated the			programming, and medication		
	following:				review.		
					· The nurse will be availab		
		hat was observed during the			do observations within the hor		
	incident in detail be	elow:"			for medical related issues as t	he	
					client's needs indicate.		
		d to take a shower by staff and			· The IDT has implemente		
	[PS #1]."				monthly staffings to ensure the		
					the team discusses the needs	of	
		get out, he wasn't going. (FC			the residents in the following		
		ke he wanted to hit staff so			areas: home, behavior, IDT's		
		e (sic) and [FC A] spit on			needed, family involvement,		
		H] went after [FC A] and they			medical, workshop/day service		
		lient H] got [FC A] on the			financial and adaptive equipm		
	-	ng him. PS (#1) tried to get			The QIDP will monitor an		
		C A]. [Client H] was hitting			review the resident's needs. A	S	
		was biting and and ripping			the needs arise, formal		
		e (FC A) also scratched his			programming will be implemen		
	(Client H's] nose ar	rea and face"			· Quarterly Health and Saf	•	
	113371 . 111	1 1 1:00 4			assessments will be complete	-	
		been done differently to			the Program Coordinator and/	Of	
	prevent a future inc	eideni?"			the Program Director and		
	W/DG ((1) N) di FEG di di di di di				forwarded to the Quality	200	
	-"(PS #1) Nothing, [FC A] needs to stop spitting				Improvement department. The		
	on others."				assessments include a review		
	A marriage - £41 DD	A.O. former dated 2/0/21			the environmental needs for the		
		AQ form dated 3/9/21			home, review of risk plans, ISI		
	indicated FC A bec	came upset when staff asked			BSP and client specific training	9	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G353	(X2) MULTIPLE A. BUILDING B. WING	OO OO	(X3) DATE SURVEY COMPLETED 06/08/2021			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	(X5) COMPLETION DATE			
	FC A threatened to in an attempt to pro indicated FC A and a result of the incide aggression on 3/9/2 recommendations for measures to prevent client aggression. 5. A BDDS report of 3/15/21, " [Client bedroom and was we being prompted by take a shower. [FC The program supervhad him apologize the supervisor checked found none. The program supervisor okay and he laughed A review of the BD indicated an incident aggression occurred The review did not effective corrective incidents of client to 4. A BDDS report of 3/18/21, " [Client while in their bedroothe bed face first. [Client and reported the incident A] for injuric okay. No injuries we will a result of the program of the public and reported the incident A] for injuric okay. No injuries we will a result of the program of the public and reported the incident A] for injuric okay. No injuries we will a result of the program o	between FC A and client A. indicate recommendations for measures to prevent further		for the residents. The assess also includes an interview of to ensure they know how to properly document medical needs, how to report incident diets and understanding of BS. Former Client A has bee moved to a new home and is currently looking at placement Waiver setting. 1.What is the date by which the systemic changes will be completed? July 8th, 2021	staff s, SP's. en t in			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			JLTIPLE CO. IILDING	NSTRUCTION 00	(X3) DATE COMPL		
THIS TETHY	or conduction	15G353	B. WI		00	06/08/	
		10000		CTDEET A	DDDEGG CITY OTATE ZID CODE	00/00/	2021
NAME OF F	PROVIDER OR SUPPLIEF	₹			ARKWAY DR		
REM OC	CAZIO LLC				SON, IN 46012		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	00	other individuals IDT					
		eam) team meet weekly to havior and meets to discuss					
	[client A] when ne						
	-A PPAQ (Peer to I	Peer Aggression Questions)					
		and completed by PS					
	(Program Superviso	or) #1 indicated the					
	following:						
	-"Please describe w	hat was observed during the					
	incident in detail be						
	1	and told staff that [FC A]					
	1 ~	bed where his butt (buttock)					
	,	ent A) was facing the wall and					
		nis pants. He (client A) said					
		up and came out in the hallway off. 'He didn't get to pull my					
	underwear down' [c						
	-"What could have	been done differently to					
	prevent a future inc	ident?"					
	UNI_41.i						
	on [FC A]."	or trying to keep a better eye					
	on [1 0 11].						
	A review of the PP	AQ form dated 3/18/21					
	indicated FC A pus	hed client A onto a bed and					
		own clients A's pants. The					
		cate documentation of an					
		ling this incident of client to					
		exually inappropriate					
	behavior. The revie	or effective corrective					
		t further incidents of client to					
	client aggression.	OI OHOIN TO					
	_	dated 4/13/21 indicated on					
	4/11/21, " [Client	A] reported to staff that [FC					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUI A. BUII		NSTRUCTION 00	(X3) DATE : COMPL		
MINDILMIN	or condition	15G353	B. WIN		00	06/08/	
		100000				00/00/	2021
NAME OF F	PROVIDER OR SUPPLIEF	8			DDRESS, CITY, STATE, ZIP CODE		
REM OC	CAZIO LLC				ARKWAY DR SON, IN 46012		
(X4) ID	SUMMARYS	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	P	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	A] was messing wit	th [client A's] smart TV and					
		him to stop [FC A] hit [client					
	A]. [Client A] left t	he room and went to report					
	the event to staff. S	taff checked [client A] for					
	injuries and made s	ure that he was okay. No					
		. Staff spoke with [FC A]					
	about not putting hi	-					
		other individuals IDT team					
		scuss [FC A's] behavior and					
	meets to discuss [cl	ient A] when needed".					
	-A review of the BI	DDS report dated 4/13/21					
	indicated an incider						
	aggression occurred	d between FC A and client A.					
	The review did not	indicate recommendations for					
	effective corrective	measures to prevent further					
	incidents of client to	o client aggression.					
	8. A BDDS report of	dated 4/19/21 indicated, "					
	On 4/18/21 [FC A]	scratched client C's face. No					
	medical treatment v	vas needed. Staff cleaned the					
		ed the nurse and [client C's]					
	_	e wanted to press charges due					
		ons with [client C] about [FC					
	'	upervisor called the police and					
		report. An alternative					
		aggested to the parents. The nen did not want to have them					
		to keep them separated. They					
	1 -	d make them uncomfortable to					
		conment. The team suggested					
		e) evaluation for [FC A] due to					
		d his (FC A's) guardian did					
		ed at the time. [Client C's]					
	Mom packed him u	p for the night The IDT has					
	met and [FC A's] gr	uardian has agreed to let him					
	_	Mentor will revise both					
		Behavior Support Plan) and					
	meet biweekly for [FC A]."					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15G353	B. W	ING		06/08/	2021
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	R.		1	ARKWAY DR		
REM OC	CAZIO LLC				SON, IN 46012		
						1	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY		DATE
	•	ed 4/18/21 and completed by					
	, -	visor) #1 indicated the					
	following:						
	"Dlagge degeniher vy	hat was observed during the					
	incident in detail be						
	incident in detail be	now.					
	-"Staff [Staff #1] ca	illed me at 4:37 PM. to tell					
		living room and [client C] got					
		(Client C) to shut up. [FC A]					
	•	they got into a scuffle.					
		c) scratched up. They were					
		e were called by family					
	(Dad)."						
	, ,						
	-"What could have	been done differently to					
	prevent a future inc	ident?"					
		omes in the living room					
	messing with other	peers often."					
		d 4/18/21 and completed by					
	staff #1 indicated th	ie following:					
	"D1 1 '1	h-4					
	incident in detail be	hat was observed during the					
	merdent in detail be	now.					
	-"[FC A] went to st	aff (Me). [Client C] told [FC					
		e. [FC A] told him (client C]					
	_	ve] up or I'm going to					
		[FC A] went to hit [client C].					
		the hit [FC A] scratched					
		(sic). The fight was able to be					
	stopped."	5					
	-"Was there any inj	ury?"					
	, , <u>.</u>	C] scratches on his face. First					
	Aid was done (sic).	"					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LTIPLE CO. LDING	NSTRUCTION 00	(X3) DATE (COMPL		
MINDILMIN	or condenion	15G353	B. WIN		00	06/08/	
		100000	Щ,			00/00/	2021
NAME OF F	ROVIDER OR SUPPLIER	8			DDRESS, CITY, STATE, ZIP CODE		
REM OC	CAZIO LLC				ARKWAY DR SON, IN 46012		
(X4) ID		TATEMENT OF DEFICIENCIES	,	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	F	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		been done differently to		TAG	DEFICIENCE		DATE
	prevent a future inc						
	prevent a ratare me	ident.					
	-"Keep them apart.'	•					
	A raviany of the DE	AQ forms indicated an				ļ	
		client aggression between					
		occurred on 4/18/21. The					
		ent C sustained scratches to					
	his face. The review	v indicated client C's father					
		to be called to report client					
	,	view did not indicate					
		or effective corrective					
	•	t further incidents of client to					
	client aggression.						
	9. A BDDS report of	lated 4/25/21 indicated on					
	_	ndividuals were in the living					
		insport to take them to Day					
	Services, [FC A] be	came upset when [client A]					
	_	Client A] was not curing (sic)					
		A] told [client A] to stop or he					
	1 1	rt [client A] to his room. [FC					
		ent A] and reached out to him ped [FC A] and bent his fingers					
		rer and prompted the					
		ate and [FC A] then turned and					
	-	[Client A] chased [FC A]					
	down the hallway, p	oushed him down, and stomped					
		Both staff followed and one of					
		separate the individuals.					
	_	ogram supervisor and 911					
		es) in order to have [FC A]					
	•	ble head injury. The police and Medical Services) came to the					
		olice spoke to the individuals					
		t happened. [FC A] refused to					
		e to the ER (Emergency					
		ram Supervisor took him to					
		a's] vitals were found to be					
			- 1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G353		ľ	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 06/08 /	ETED		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012					
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
TAG	REGULATORY OR	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE	
	assessed him (FC A	s and after the ER doctor all that was found was a forearm. [FC A] was released ome".						
	Individual Interview indicated the follow	v forms dated 4/23/21 ring:						
	-"Individual Intervi Support Professiona	ewed: [Staff #2], DSP (Direct al)						
	-(Staff #2) "Stated s group home] on 4-2	she was working at [name of 3-21."						
	-(Staff #2) "Stated she was sitting in the living room with the individuals waiting for transport at 6:30 am."							
	, ,	she heard [client A] using s not cursing at [FC A]."						
		hat [FC A] told [client A] to escort [client A] to his						
	[client A] and reach	hat [FC A] walked over to ned out to grab him, but [client] hand and bent his fingers						
	intervene but [FC A	she (staff #2) tried to L] ran down the hallway past [client A] chased him."						
	saw both guys runn	hat the other staff, [staff #3], ing down the hallway and d. room to see what was						
	-(Staff #2) "Stated t	hat [client A] pushed [FC A]						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			UILDING	NSTRUCTION 00	(X3) DATE COMPL		
		15G353	B. W	ING		06/08/	/2021
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>	•		DDRESS, CITY, STATE, ZIP CODE	•	
REM OC	CAZIO LLC				ARKWAY DR SON, IN 46012		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	and [FC A] hit his h	nead on the ground."					
		that [client A] stomped on [FC s before [staff #3] was able to uals".					
	-"Individual Intervi	ewed: [Staff #3], DSP".					
	-(Staff #3) "Stated s group home] on 4-2	she was working at [name of 13-21."					
	-(Staff #3) "Stated was passing med's in the staff office at 6:30 am."						
	-(Staff #3) "Stated she saw [FC A] running down the hallway past the med. room and that [client A] was chasing him."						
		she got up to see what was she saw [client A] catch up to m to the ground."					
		hat [client A] stomped on [FC s before she was able to get he individuals."					
	-(Staff #3) "Stated [floor when he fell	[FC A] hit his head on the					
	-"Individual Intervi	ewed: [Client A], Individual".					
	-(Client A) "Stated home] on 4-23-21."	he was at [name of group					
	-(Client A) "Stated making noises."	he was laying on the couch					
	-(Client A) "Stated	[FC A] tried to hit him."					
	-(Client A) "Stated	he ran after [FC A], threw him					

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AND PLAN OF CORRECTION IDEN		IDENTIFICATION NUMBER: 15G353	ì í			COMPLETED 06/08/2021				
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR						
REM OCCAZIO LLC					SON, IN 46012					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE			
	on the floor, and stomped on [FC A's] face with his foot."									
	-(Client A) "Stated	he didn't have shoes on."								
	-(Client A) "Stated that [staff #3] saw what happened and calmed him down."									
	-(Client A) "Stated that [staff #3] was in the staff office passing med's."									
	-(Client A) "Stated he threw [FC A] down and stomped on him because he (client A) felt rage from stuff that [FC A] had done to him in the past."									
	-(Client A) "Stated he was angry from things [FC A] has done to him before. (Past peer to peer incidents)".									
	A review of the BDDS report and Individual Interview statements dated 4/25/21 and 4/23/21 indicated client A pushed FC A down to the floor and kicked FC A in the face. The review did not indicate recommendations for effective corrective measures to prevent further incidents of client to client aggression.									
	On 5-11-21 IN (Ind complaint regarding [client A]. The com was being physicall The complainant all and hit [client A]. Turinated in [client A] were roommates) ca complainant express of [FC A's] television	dated 5/12/21 indicated, " iana) Mentor received a g [FC A's] behavior toward plainant alleged that [FC A] y abusive towards [client A]. leged that [FC A] has slapped that [FC A] has defecated and c's] room (the two individuals ausing the room to smell. The sed concerns over the volume on in the room. The dicated that [FC A] had								

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· · · · · · · · · · · · · · · · · · ·		IDENTIFICATION NUMBER:		ULTIPLE CO JILDING	NSTRUCTION 00	(X3) DATE COMPL			
15G353		B. W	ING		06/08/				
				STREET A	ADDRESS, CITY, STATE, ZIP CODE				
NAME OF PROVIDER OR SUPPLIER			1012 PARKWAY DR						
REM OCCAZIO LLC				ANDER	SON, IN 46012				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX TAG				PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE		
IAG		nappropriately The two men		IAG	Dia reliate 17		DATE		
		n rooming together on							
	_	s] guardian to discuss other							
		options; waiver (supported							
		re discussed and the guardian							
		c) as that might be a more							
	appropriate fit for []	rc Aj							
	-A review of the BI	DDS report dated 5/12/21							
		y received a complaint							
	alleging FC A was j	physically abusive to client A.							
		ed the facility received a							
		FC A touched client A							
	inappropriately. The review indicated the facility								
	moved FC A out of client A's bedroom on 5/11/21.								
	3/11/21.								
	11. A BDDS report dated 5/12/21 indicated, "								
	_	sentative from APS (Adult							
) arrived at the home. The							
		that they were there to							
	_	gation regarding [client C]							
		S reports the mother of hem of concerns to [client							
	1	FC A] residing in the home.							
		t his mother informed them							
		nich [FC A] was physically							
	aggressive toward[client C] and scratched [client								
	_	on 5/12/21 with [FC A's]							
	_	potential placement options							
	due to the APS concerns in the home between the two men. Guardian for [FC A] was open to exploring a different group home option while the waiver process was being completed. Documents to start the waiver process were provided by IN Mentor to BDDS for [FC A] on								
	5-12-21. On 5-13-2	1 [FC A's] guardians toured							
		home option and agreed that							
		a good fit for [FC A]. The							
	LOC (Level of Care	e) was completed by BDDS							

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· ·		IDENTIFICATION NUMBER:		ULTIPLE CO UILDING	NSTRUCTION 00	(X3) DATE COMPL			
15G353		B. W	B. WING		06/08/2021				
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR						
REM OC	CAZIO LLC			ANDER	SON, IN 46012				
(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 APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE		
	5-13-21. Transition with guardian, Men Staff training for [F home is being comp will move into his read a review of the BD indicated the facility regarding allegation towards client C. The moved to a new growards and was not able to Client A was interved lient A stated, "You A was asked if FC A client A stated, "You A was asked if FC A client B." Client A stated injuries as aggression by FC A C] had a scar on his scratches on [client asked if he was afra "Probably just nervesomeone again." Client D was interved lient D was asked Client D stated, "No stern voice he woule everyday since he gif FC A had hit any stated, "I've heard he seen it."	mergency basis and approved meeting was (sic) completed tor and BDDS on 5-13-21. C A] with the staff at the new pleted on 5-14-21. [FC A] new home on 5-14-21." DS report dated 5/12/21 by received a complaint as of physical abuse by FC A ne review indicated FC A was pup home on 5/14/21. The aresident at the group home be interviewed. The aresident at the group home be intervi							

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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 00 COMPLETED B. WING 06/08/2021				ETED			
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1012 PARKWAY DR ANDERSON, IN 46012					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Client B was asked if client C had ever been hurt by FC A. Client B stated, "Yes, I seen him one			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	3 RIATE	(X5) COMPLETION DATE		
	Client B was asked if client C had ever been hurt								

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	ETED	
15G353		15G353	B. WI	NG		06/08/	/2021	
				STREET	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER	L			ARKWAY DR			
DEM OC	CAZIO LLC			_				
			ANDERSON, IN 46012					
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE	
	, -	ctor) #1 was interviewed on						
		RD #1 was asked why FC A						
		ne group home on 5/14/21.						
	RD #1 stated, "Because of the increase in							
	physical aggression and we had family members							
	that requested he move." RD #1 was asked why							
	FC A was moved out of the room with client A.							
	RD #1 stated, "We separated the two of them							
	because [client A's] grandmother called in a							
	concern and request	ted they not room together						
	any longer." RD #1	indicated the facility could						
	not provide docume	entation of any complete,						
	thorough investigat	ions or effective corrective						
	measures to prevent	t multiple incidents of client						
	to client aggression	, allegations of physical						
	abuse by FC A towards client C or regarding							
	allegations of physical abuse and inappropriate touching by FC A towards client A.							
	This federal tag relates to complaint							
	#IN00353635.							
	9-3-2(a)							

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