

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/06/2013
NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401		
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Survey dates: March 1, 4, 5 and 6, 2013.</p> <p>Facility number: 000823 Provider number: 15G304 AIM number: 100249090</p> <p>Surveyor: Steven Schwing, Medical Surveyor III</p> <p>The deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed March 12, 2013 by Dotty Walton, Medical Surveyor III.</p>	W000000			

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W000104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview for 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the governing body failed to exercise operating direction over the facility by failing to ensure the dryer vent was in good repair.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 3/4/13 from 3:22 PM to 6:28 PM. At 5:23 PM, there was a 4 inch hole in the dryer vent exhaust hose. The dryer vent exhaust hose was lying on the floor next to the dryer. The dryer was on and the exhaust from the dryer hose was venting into the laundry room. This affected clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>An observation was conducted at the group home on 3/5/13 from 5:55 AM to 7:33 AM. The dryer vent hose had a 4 inch hole in the line. This affected clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>An interview with Administrative Staff (AS) #2 was conducted on 3/5/13 at 12:02 PM. AS #2 indicated the home manager</p>	W000104	On 3/6/13, the dryer vent was fixed and restored without incident. Monthly checks of the vent will be completed to ensure all necessary repairs are completed as needed to ensure safety.	03/07/2013			

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	(HM) should have noted the hole in the dryer hose. AS #2 indicated the HM was responsible for conducting assessments of the home. AS #2 indicated the staff working at the home should have noted the hole and submitted a work order to get the hose replaced.  9-3-1(a)			

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W000120	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</p> <p>The facility must assure that outside services meet the needs of each client. Based on observation, record review and interview for 1 of 1 client who attended workshop #3 (client #1), the facility failed to ensure the workshop staff implemented client #1's mealtime plans.</p> <p>Findings include:</p> <p>An observation was conducted at workshop #3 on 3/4/13 from 11:27 AM to 12:20 PM. At 11:59 AM, client #1 went to eat his lunch. Client #1 ate a sandwich, potato chips, yogurt, 2 fruit cups and raisins. Client #1 had a Diet Coke to drink. During client #1's lunch, client #1 did not alternate drinks and bites of food. The workshop staff did not prompt client #1 to alternate his drinks and bites of food. The workshop staff did not prompt client #1 during lunch to alternate his drinks and bites of food.</p> <p>A review of client #1's record was conducted on 3/5/13 at 9:19 AM. Client #1's Swallow Study, dated 7/8/10, indicated, "[Client #1] will take small bites with a slow rate of intake while eating, alternating with sips of liquid." Client #1's Choking Protocol, dated 1/20/12, indicated, in part, "Staff remind</p>	W000120	<p>Workshop was given a copy of client's updated ISP and retrained on his dining plan on 3/20/13. An observation was also completed on this day. Monthly meetings with workshop will be held to ensure workshop staff have all appropriate documents pertaining to the programming of client and staff were trained on this plan on 3/20/13. Addendum: Home Manager and/or Program Director will complete an observation of client during mealtime at workshop once weekly for 4 weeks, followed by monthly observations for 3 months. Workshop was given a copy of client's updated ISP and retrained on his dining plan on 3/20/13. An observation was also completed on this day. Monthly meetings with workshop will be held to ensure workshop staff have all appropriate documents pertaining to the programming of clients.</p>	03/20/2013

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	<p>to eat at a slower rate and to swallow before next bite. Staff to encourage small bites of food at slow pace while alternating sips of liquids." Client #1's Dining Plan, dated 1/20/12, indicated, in part, "Staff to have [client #1] in view and remind him to drink slow consumption of thin liquids; to take small bites of food at slow pace while alternating with sips of liquids (at least every 3-4 bites)." Client #1's Aspiration Protocol, dated 1/20/12, indicated, in part, "[Client #1] needs to drink slow consumption of thin liquids. To take small bites of food at slow pace while alternating with sips of liquids (at least every 3-4 bites)."</p> <p>An interview with Administrative Staff (AS) #2 was conducted on 3/5/13 at 12:02 PM. AS #2 indicated the workshop staff should implement client #1's mealtime plans as written.</p> <p>An interview with the Program Director (PD) was conducted on 3/5/13 at 12:22 PM. The PD indicated the workshop staff should ensure client #1's mealtime plans were implemented as written.</p> <p>9-3-1(a)</p>						

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W000125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, interview and record review for 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to ensure the clients had the right to due process in regard to receiving training on reporting suspected abuse and neglect.</p> <p>Findings include:</p> <p>An observation was conducted at workshop #1 on 3/1/13 from 1:05 PM to 2:00 PM. At 1:25 PM, client #2 was interviewed after indicating he wanted to talk to the surveyor. Client #2 stated client #3 was involved in an "altercation" with staff #12 "last Thursday." Client #2 stated staff #12 "maybe" used an inappropriate restraint on client #3. Client #2 stated the incident occurred "last night" when everyone was getting ready to go to the YMCA. Client #2 stated he did not want to see anyone "get hurt." Client #2 indicated staff #12 did not hurt client #3. Client #2 stated client #3 was "taken to the floor" by staff #12 after client #3 grabbed staff #12 in a</p>	W000125	A household client meeting was held on 3/21/13 wherein all clients were trained on how to appropriately report incidents that they feel are concerning. Clients were also provided with a "grievance form" to fill out if they feel necessary.	03/21/2013			

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	<p>headlock. Client #2 indicated staff #8 and #12 were at the home at the time of the incident. Client #2 indicated he did not report his concerns to anyone. Client #2 indicated he was waiting to tell the surveyor (client #2 did not know the surveyor opened a survey at his home at the time of the visit to the workshop).</p> <p>An interview with the Area Director (AD) was conducted on 3/1/13 at 2:01 PM. The surveyor contacted the AD to report the allegation of an inappropriate restraint involving client #3. The AD indicated he was not aware of a restraint at the home on 2/28/13 and had not been contacted. The AD indicated there were no calls to the pager. He indicated he would look into the incident.</p> <p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS) incident report was conducted on 3/5/13 at 12:28 PM. The BDDS report, dated 3/1/13, indicated, in part, "On 2/28/13 Bloomington Group Home resident [client #3] was put into two separate physical restraints after reportedly becoming physically assaultive to staff by spitting on a staff and putting this DSP (Direct Support Professional) into a headlock. Investigation pending."</p> <p>An interview with the Program Director</p>						

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	<p>(PD) was conducted on 3/5/13 at 12:22 PM. The PD indicated she was first aware of the restraints as she was leaving work on 3/1/13. The PD indicated the on-call staff was not notified of the incident on 2/28/13. The PD indicated the home manager was at the home at the time of the restraints but did not know they occurred. The PD indicated both staff indicated the HM had to know about the incidents. The PD indicated the staff received corrective actions for not reporting the restraints. The direct care staff indicated they did not report the restraints due to thinking the HM was going to report them. The PD indicated she was conducting the investigation of the incident but did not know about a client's concerns of the use of an inappropriate restraint. The PD indicated she was not asked to look into the use of an inappropriate restraint. The PD indicated she had no documentation clients #1, #2, #3, #4, #5, #6, #7 and #8 received training on reporting their concerns to administrative staff. The PD indicated she had discussed this with the clients on numerous occasions but did not have documentation the training occurred.</p> <p>9-3-2(a)</p>				

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W000248	<p>483.440(c)(7) INDIVIDUAL PROGRAM PLAN</p> <p>A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on observation, record review and interview for 1 of 1 client who attended workshop #3 (client #1), the facility failed to ensure the workshop had client #1's current Individual Support Plan (ISP).</p> <p>Findings include:</p> <p>An observation was conducted at workshop #3 on 3/4/13 from 11:27 AM to 12:20 PM. During the observation, client #1's records at the workshop were reviewed. The ISP in client #1's record at the workshop was dated 8/17/11.</p> <p>A review of client #1's record was conducted on 3/5/13 at 9:19 AM. Client #1's current ISP was dated 8/17/12.</p> <p>An interview with workshop administrative staff #1 was conducted on 3/4/13 at 12:11 PM. Workshop administrative staff #1 stated, "Can't tell you the last time we got anything from them."</p> <p>An interview with Administrative Staff (AS) #2 was conducted on 3/5/13 at 12:02</p>	W000248	Workshop was given a copy of client's updated ISP and retrained on his dining plan on 3/20/13. An observation was also completed on this day. Monthly meetings with workshop will be held to ensure workshop staff have all appropriate documents pertaining to the programming of clients.	03/20/2013

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	<p>PM. AS #2 indicated the workshop should have client #1's current plan.</p> <p>9-3-4(a)</p>			

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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review and interview for 1 of 4 sampled clients (#1), and one additional client (#4) observed to receive their medications from staff #6, the facility failed to ensure the staff implemented the clients' medication administration training objectives.</p> <p>Findings include: An observation was conducted at the group home on 3/5/13 from 5:55 AM to 7:33 AM. At 6:27 AM, client #4 received his medications from staff #6. His medications included Benzotropine (Extrapyramidal symptoms), Fish oil (hyperlipidemia), Loratadine (allergic rhinitis), Ziprasidone (schizophrenia), Lorazepam (anxiety), Lisinopril (hypertension), Amoxicillin (antibiotic), Desonide (dry skin), Triamcinolone (dry skin) and Pepsodent toothpaste. Client #4 was not prompted to find two medications he was supposed to take on the Medication Administration Record (MAR) and place a dot in the correct spot as staff got them out. Client #4 was not</p>	W000249	Staff meeting was held on 3/20/13 where all staff were retrained on goal implementation during medication administration. Med Administration observations were also completed to ensure that goals were being done correctly and consistently. Staff responsible for failing to work on med goals was given Corrective Action.	03/20/2013

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	<p>prompted to initial the MAR after taking his medications.</p> <p>At 6:37 AM, client #1 received his medications from staff #6. His medications included Bzotropine (neuroleptic), Clonidine (impulse control), Loxapine (impulse control), Olanzapine (psychosis), Oxybutynin (urinary incontinence), Stool softener (constipation), Zonisamide (seizures), Artificial Tears (dry eyes), Amoxicillin (antibiotic), Reguloid (constipation), Venastat (circulation), Lisinopril (blood pressure), X-viate (dry, scaly feet), and Amitriptyline (antidepressant). Staff #6 did not prompt client #1 to identify and state the purpose of two of the behavior medications.</p> <p>A review of client #4's record was conducted on 3/5/13 at 9:23 AM. Client #4's Individual Support Plan (ISP), dated 2/18/13, indicated he had a medication training objective to find two medications he was supposed to take in his copy of the Medication Administration Record (MAR) and place a dot in the correct spot as staff get them out and will initial the MAR after taking medications.</p> <p>A review of client #1's record was conducted on 3/5/13 at 9:19 AM. Client #1's ISP, dated 2/18/13, indicated he had a medication training objective to identify and state the purpose of two of his behavior medications.</p>						

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	<p>An interview with the Program Director (PD) was conducted on 3/5/13 at 12:22 PM. The PD indicated the clients' medication training objectives should be implemented at each medication pass.</p> <p>An interview with Administrative Staff (AS) #2 was conducted on 3/5/13 at 12:02 PM. AS #2 indicated the clients' medication training objectives should be implemented at each medication pass.</p> <p>9-3-4(a)</p>			

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W000312	<p>483.450(e)(2) DRUG USAGE</p> <p>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for 1 of 3 clients in the sample with psychotropic medications (#6), the facility failed to ensure there was a plan to reduce client #6's psychotropic medication.</p> <p>Findings include:</p> <p>A review of client #6's record was conducted on 3/5/13 at 11:09 AM. A review of his Physician's Orders, dated 3/1/13 through 3/31/13, indicated he was prescribed Invega Sustenna as an injection every 4 weeks starting on 2/20/13. Client #6's most recent psychiatrist appointment documentation, dated 2/12/13, indicated he was prescribed Invega Sustenna every 4 weeks for intermittent explosive disorder. The form indicated the titration/medication reduction plan was "based on behavioral information, clinical presentation, and clinical judgment." His Behavior Support Plan (BSP), dated 11/12, did not include documentation of client #6 taking a psychotropic medication. The BSP did not include a plan to reduce the use of the</p>	W000312	Client's medication reduction plan for psychotropic medications was put into place and staff were trained on this plan on 3/20/13. Addendum: Teams will review client Behavior Support Plans following psychiatric medication changes or annually to ensure titration plan is current and accurate. Client's medication reduction plan for psychotropic medications was put into place and staff were trained on this plan on 3/20/2013.	03/20/2013

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	<p>psychotropic medication. There was no plan of reduction in client #6's record for his psychotropic medication.</p> <p>An interview with the Area Director (AD) was conducted on 3/6/13 at 12:03 PM. The AD indicated there should be a plan of reduction for client #6's psychotropic medication. The AD indicated a plan was created previously however he was unable to locate the plan.</p> <p>9-3-5(a)</p>			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W009999	<p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p> <p>460 IAC 9-3-1 Governing Body</p> <p>(b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division. (Use of any physical or manual restraint regardless of: a. planning; b. human rights committee approval; c. informed consent).</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 2 of 14 incident reports reviewed affecting clients #3 and #6, the facility failed to ensure restraints were reported to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility's</p>	W009999	On 3/20/13 Program Director received Corrective Action and retraining on reporting guidelines.	03/20/2013			

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	<p>incident/investigative reports was conducted on 3/1/13 at 11:13 AM and 3/4/13 at 10:33 AM.</p> <p>1) On 2/5/13 at 6:50 PM, client #6 was restrained by staff for "approximately 15 minutes" after assaulting staff. The incident was reported to BDDS on 2/7/13.</p> <p>2) On 2/5/13 at 6:50 PM, client #3 was restrained by staff for 10 minutes after physically assaulting a staff. The incident was reported to BDDS on 2/7/13.</p> <p>An interview with the Program Coordinator (PC) was conducted on 3/5/13 at 12:22 PM. The PC indicated BDDS reports should be submitted within 24 hours of the incident.</p> <p>An interview with Administrative Staff (AS) #2 was conducted on 3/5/13 at 12:02 PM. AS #2 indicated BDDS reports should be submitted within 24 hours.</p> <p>9-3-1(b)</p>				