

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  10/30/2015
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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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W 0000  Bldg. 00	<p>This visit was for a Post Certification Revisit (PCR) to the investigation of complaint #IN00180377 completed on 9/16/15.</p> <p>Complaint #IN00180377: Not Corrected.</p> <p>Dates of Survey: October 29 and 30, 2015</p> <p>Facility number: 000823 Provider number: 15G304 AIM number: 100249090</p> <p>This deficiency also reflects state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 11/2/15.</p>	W 0000		
W 0149  Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 3 of 4 incident/investigative reports reviewed affecting clients C, D, F and H, the facility neglected to implement its</p>	W 0149	The designated drop off location for Client D in the afternoons after he completes his day services programming has been changed to be at the Bloomington TSI	11/29/2015

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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	<p>policies and procedures to prevent client D from being dropped off at the group home by community transportation when no staff was present and two incidents of client to client abuse.</p> <p>Findings include:</p> <p>On 10/29/15 at 3:28 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 10/11/15 at 6:30 PM, client C was getting the left over food off the pan for his lunch. Client F called client C names and screamed at him. Client C called client F names. Staff separated the clients. Client H ran over screaming at clients C and F. Client F grabbed client H by the front of his shirt and left two scratches on client H's neck. The investigation, dated 10/16/15, indicated staff #6 reported, "[Staff #6] stated that the incident started over leftover chicken from dinner. She said everyone was helping after dinner. [Client C] was taking some leftover chicken out of the pan and [client F] started getting mad that he wanted it and took empty pan from [client C]. [Staff #10] asked [client F] for the empty pan and put (sic) in sink to run water on it. [Clients C and F] were still mad at each other so [staff #6] was</p>		<p>office/day program site so he will not be dropped off at the home any longer which could potentially result in him being dropped off without supervision. Staff in the home will be continually retrained on preventing client to client abuse. Observations will continue with 2 observations weekly for two weeks and then weekly ongoing.</p>	

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	<p>standing by [client F] in the dining room and [staff #10] was asking [client C] to leave the room for a minute. [Client C] started to walk to his room and calm down when [client H] who was sitting at the head of the dining table (towards living room) jumped up out of his seat and called [client F] 'b----.' [Staff #6] said she was in between the two so when [client F] grabbed his (client H) she was able to hold his wrist to try and get him to release the shirt. [Staff #10] came to help her. [Client F] let go and the rest of the evening was quiet. [Staff #6] said she checked [client H's] neck and he had two scratches and they just cleaned them using basic first aid." The Recommendations of the investigation indicated, "Staff in home will continue to train in preventing client to client aggression. Team to meet and discuss [client H's] increasing behaviors in initiating these types of incidents."</p> <p>On 10/30/15 at 10:40 AM, the Area Director (AD) indicated client to client aggression was considered abuse and the facility should prevent abuse. The AD indicated the facility had a policy and procedure prohibiting abuse of the clients. The AD indicated client H's team had not met to discuss his increase in intervening during other clients' behaviors. The AD indicated he sent a</p>			

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	<p>message to set up the meeting with client H's team to the behaviorist.</p> <p>2) On 9/30/15 at 4:00 PM, client D was dropped off at the group home by community transportation. There was no staff present when he was dropped off at the group home. The investigation, dated 10/5/15, indicated, "On 9/30/2015 it was reported that client [D] who uses [public transportation] bus to go back and forth to day program was dropped off at (sic) group home when no one was there. [Client D's] drop off time is usually at 3:53 PM and staff are scheduled to 3 to ensure someone is at home when he arrives. This investigation is being done to determine staff neglect." The investigation indicated client D reported when he was dropped off at the group home, no one was at home. Staff #6 indicated in the investigation when she arrived to the group home client D was sitting in the living room. Staff #4 indicated in the investigation she texted the Home Manager (HM) at 12:30 PM to let her know she could not be at work today. The HM texted her back around 4:30 PM to ask if she had found someone to cover her shift. The HM indicated in the investigation she did not receive a text from staff #4 until 4:30 PM after client D had already been dropped off. The HM indicated the public</p>			

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	<p>transportation driver usually honks to make sure a staff was at the group home. The Investigation Summary indicated, "[Client D] was dropped off at the group home from [public transportation] without a staff present. [Staff #6] discovered [client D] at home when she arrived at approximately 4:20 PM meaning [client D] was at home alone for approximately 25 minutes. [Staff #4] was scheduled at 3:00 PM and had texted [HM] at 12:30 PM that she would not be able to make it in today. [HM] stated she did not receive the text till 4:30 PM. [AD] review (sic) their text messages and what each party stated was true. [Staff #4] will receive corrective action for not following call-off procedure which states to talk to someone, not text a call off or leave a voice mail, if your supervisor can not be reached you are to call the office during business (hours) to relay the information. [Client D] suffered no ill effects from being at (sic) house alone for that period of time." The Conclusion of the investigation indicated, "Evidence supports staff did not follow protocol(s)." The Recommendations section of the investigation indicated, "[Staff #4] will receive corrective action in regards to not following call off procedure/House staff will be retrained on call off procedures."</p> <p>On 10/29/15 at 3:34 PM, the AD</p>			

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	<p>indicated client D was now being transported to the facility-operated day program instead of the group home. The AD indicated the policy was for staff to talk to someone when they were calling off work. The AD indicated he checked the HM and staff #4's texts to each other on their phones and what they reported was accurate. The AD indicated client D was unsupervised for 25 minutes. The AD indicated the clients at the group home could not be left unsupervised for any length of time.</p> <p>On 10/30/15 at 10:40 AM, the AD indicated the incident was neglect. The AD indicated staff #4 received a corrective action for not implementing the call-off procedures.</p> <p>3) On 9/24/15 at 5:00 PM, clients F and H shoved each other. Client H was antagonizing client F and called him a "b---" and shoved him lightly. Client F shoved client H and staff intervened. The investigation, dated 9/30/15, indicated in the Incident Summary, "[Client H] had been calling [client F] names such as 'b---'." Staff redirected [client H] out of the room, but [client F] grabbed [client H] by the throat area by his shirt to push him and staff immediately intervened and got between them. Staff #4 indicated in the investigation, "...[client C] had come up</p>			

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	<p>and given her a hug and she reminded him of space and that's when [client F] yelled at [client C] and [client C] yelled back. She asked [client C] to step away and was getting [client F] to calm down. [Client F] and her (sic) were in the kitchen and [client H] started calling [client F] names. [Staff #4] stood in the open doorway between the kitchen and dining area. [Staff #3] came over and was trying to encourage [client H] to go with her. It was at that point [client F] pushed through both staff to push [client H]. [Client F] pushed [client H] with both hands on his upper chest. [Client H] did not fall, staff got in front of [client H] and [client F] again and this time was able to direct the guys to different areas of the home. She and [staff #3] checked [client H] for injuries and none were (sic) found."</p> <p>On 10/30/15 at 10:40 AM, the Area Director (AD) indicated client to client aggression was considered abuse and the facility should prevent abuse. The AD indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>The facility's policy and procedures related to abuse and neglect were reviewed on 10/30/15 at 10:47 AM. The facility's Quality and Risk Management</p>			

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	<p>policy dated April 2011 indicated, "Indiana MENTOR promotes a high quality of service and seeks to protect individuals receiving Indiana MENTOR services through oversight of management procedures and company operations, close monitoring of service delivery and through a process of identifying, evaluating and reducing risk to which individuals are exposed." The policy defined neglect as, "e. Failure to provide appropriate supervision, care or training; f. Failure to provide a safe, clean and sanitary environment; g. Failure to provide food and medical services as needed; h. Failure to provide medical supplies or safety equipment as indicated in the ISP." The Human Rights policy, dated April 2011, indicated, in part, "The following actions are prohibited by employees of Indiana MENTOR: abuse, neglect, exploitation or mistreatment of an individual including misuse of an individual's funds; or violation of an individual's rights." The policy indicated, in part, "Indiana MENTOR programs maintain a written list of rights, which take into account the requirements of applicable laws, regulations, and purchasing agencies. This list of rights should include, but is not limited to: e. Ensure the clients are not subjected to physical, verbal, sexual, or psychological abuse or punishment."</p>			

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	<p>This deficiency was cited on 9/16/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to complaint #IN00180377.</p> <p>9-3-2(a)</p>				