

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/30/2012	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460			
(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		
W0000	<p>This visit was for the investigation of complaint #IN00106828.</p> <p>Complaint #IN00106828 - Substantiated , Federal and State deficiencies related to the allegation(s) cited at W149, W154 and W186.</p> <p>Unrelated deficiencies cited.</p> <p>Survey Dates: April 27 and 30, 2012.</p> <p>Facility Number: 000824 Provider Number: 15G305 AIM Number: 100249060</p> <p>Surveyor: Steven Schwing, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review completed on 5/4/12 by Tim Shebel, Medical Surveyor III.</p>	W0000					

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/30/2012	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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			
W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on record review and interview for 8 of 23 incident/investigative reports reviewed affecting clients A, B, C, D, E, F, G and H, the facility failed to implement its policies and procedures to prevent client to client abuse and neglect.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 4/27/12 at 10:40 AM.</p> <p>-On 4/12/12 at 6:00 AM, former staff #11 admitted to "dozing off" while completing paperwork. A second staff (#3) indicated when she arrived at 6:00 AM, staff #11 was asleep on the couch with his head up, a pen in his hand and the documentation book in his lap. Staff #3 indicated staff #11 was "difficult to wake up." The conclusion of the investigation indicated, "There is evidence to support that [staff #11] had fallen asleep on 4/12/2012 while on duty and while completing his DSRs (daily support records) from working the overnight shift on 4/12/2012." This affected clients A, B, C, D, E, F, G and H.</p> <p>-On 4/6/12 at 5:00 PM, client E went outside to sit on the front porch to smoke.</p>	W0149	<p>The facility is committed to implementing its written policies and procedures to prohibit mistreatment, neglect or abuse of clients. Administrative staff that support this home were retrained on Abuse and Neglect policies, procedures and prevention on 5/18/2012. (See attached) Staff in the home were retrained on the prevention of abuse and neglect of clients on 5/4/2012. Staff in the home were retrained on Active Treatment and following individual client's plans on 4/27/2012, 5/4/2012, and 5/11/2012. Staff in the home were retrained on a review of client protocols, dining plans to follow to prevent choking, and Client E's updated fall protocol with all equipment to keep him safe on 5/1/2012. (See attached) Corrective actions were completed with staff that failed to follow client specific plans as determined during investigations that were completed. Observations have been completed by Administrative Staff, and will continue to be completed, to ensure that the trainings provided are being implemented for client safety. Staff Responsible: Home Manger, Program Director, Area Director, Quality Assurance</p>	05/30/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/30/2012	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460			
(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			
	<p>Staff #4 assisted client E to get outside and to sit in a chair. Another client's guardian, who was visiting the home, called out to staff #4 to come inside for a minute. Staff #4 went into the home. As staff #4 went back outside, she observed client E trying to get up from the chair. Client E's walker slipped out from under him and he fell backward onto his bottom, hitting his head on the ground. Client E was taken to hospital with tests indicating normal results with the exception of a couple of minor scrapes and scratches (no details of injuries). The conclusion of the investigation indicated, "There is evidence to support that [client E] had fallen causing him to hit his head. There is evidence to support that staff were NOT side by side with [client E] at the time of the fall. There is evidence to support that staff followed aspects of [client E's] fall protocol."</p> <p>A review of client E's fall protocol was conducted on 4/30/12 at 2:53 PM. The protocol, dated 3/2/12, indicated the following, "[Client E] is to wear a gait belt from the time he gets up in the morning until he goes to bed at night, and if he gets up during the night. Staff are to be at [client E's] side at all times when he is up ambulating or when he transfers. Staff are to be 1 on 1 (one on one staffing) with [client E] and [client E] is</p>		Specialist, Nurse. Date of Completion: 5/30/12				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/30/2012
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460		
(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	
	<p>to have 'NO FALLS' as staff are to be at his side at all times when transferring or ambulating... THERE ARE NO EXCEPTIONS TO ABOVE INSTRUCTIONS."</p> <p>-On 4/4/12 at 6:30 PM, client D "wandered away" from the group home while two staff were working (staff #5 and #8). An interview with Administrative staff (AS) #1, included in the investigation, indicated a previous staff member observed client D walking outside by the group home. The former staff picked him up and brought him back to the home.</p> <p>An interview with staff #8 included in the investigation indicated while she and staff #5 were assisting client E into the home due to his unsteadiness, client D got up off the couch and went outside. Staff #8 indicated she kept client D in line of sight except for less than one minute while she assisted client E to the couch. Staff #8 then went outside to get client D who was on the sidewalk about 2 houses down from his house. Staff #8 indicated client D returned to the home after approximately 5 minutes of prompting. Staff #8 did not indicate a former staff member picked up client D nor was it addressed in the investigation.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/30/2012	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460			
(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			
	<p>An interview with staff #5 included in the investigation indicated she and staff #8 were assisting client E into the home due to his issues with walking. Staff #5 indicated staff #8 was keeping client D within line of sight. Staff #8 observed client D walking off the porch; staff #8 went to get client D as soon as she assisted client E to sit on the couch. Staff #5 indicated client D returned to the home after about 5 minutes.</p> <p>The conclusion of the investigation indicated, "There is evidence to support that [client D] had wandered away from the group home premises for approximately five minutes. There is also evidence to support that [client D] was in line of sight for approximately four out of the five minutes." The investigation did not address the conflicting information on how client D returned to the home. There was no documentation indicating whether or not corrective action was taken with the staff or addressing the staff to client ratio at the time of the incident.</p> <p>-On 3/2/12 at 8:30 AM, client E arrived to workshop unassisted, without his cane. While attempting to sit in a chair, client E fell backward and hit the left side of his head and left hand. He developed a raise lump on the back of his head and he was sent home. At 12:45 PM, group home</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/30/2012	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460			
(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			
	<p>staff transported client E to the hospital; no apparent injuries noted. A gait belt was implemented following the fall.</p> <p>-On 2/2/12 at 9:30 AM, client E fell causing him to hit his head and scrape his right hand (no description of the injuries in the report). He was taken to the emergency room (ER). [Client E] had several x-rays and nothing was found.</p> <p>-On 12/27/11 at 6:00 PM, client B threw a fork hitting client G on the left temple. Client G's temple had 4 prong marks and was bleeding. The conclusion of the investigation indicated, "[Client B] had a behavior and threw a fork at [client G]. Staff followed his behavior plan appropriately." Administrative staff reviewed the results of the investigation on 1/9/12.</p> <p>-On 12/6/11 at 7:45 PM, client C eloped from the group home. The investigation indicated, "[Client C] has a history of elopement which is addressed in his behavior plan." Two staff were working at the time of the incident (staff #5 and #10).</p> <p>A review of client C's record was conducted on 4/30/12 at 10:22 AM. Client C's Behavior Development Program, dated 12/28/11, indicated he had</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/30/2012	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460			
(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			
	<p>a targeted behavior of elopement (vacating). Vacating will be defined to occur only at times when [client C's] is scheduled to be in to a specified environment (e.g., group home, day program) as outlined within [client C's] program plan. Vacating is defined as leaving without informing staff or leaving a program area and not returning when called. The plan indicated, "In inclement weather, keep protective clothing for staff and [client C] near the door so that it is easily available if [client C] exits the home. Alarms are installed on the doors in the home; staff should insure that they are working at the beginning of every shift. 1. Instead of directing [client C] to cease the behavior or to come back, approach him by asking him where he is going. 2. Regardless of whether [client C] responds, tell [client C] that you will go with him. Do not talk with [client C], just stay with him. Do not chase [client C]; shadow him from behind. 3. About once every 5 minutes, ask [client C] if he is ready to return. 4. Stay with [client C] until he has returned to a safe location and keep him under observation until you are sure he will not vacate again."</p> <p>Staff #5 indicated in her interview in the investigation when she arrived for work at 6:00 PM, the door alarms were not functioning.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	<p>Staff #10 indicated in the facility's investigation when she arrived for work (no time documented) the door alarms were not functioning and did not know staff were to complete 15 minutes checks due to the door alarms not functioning. Staff #10 indicated she did not complete 15 minute checks. At 7:45 PM, staff went upstairs to prompt client C for his evening medications; the investigation revealed the staff who went upstairs did not open client C's locked door or get a response from client C. At approximately 7:50 PM or 7:55 PM, the group home received a call from police asking if they were missing a client. The police brought client C back to the group home "shortly after" 8:00 PM.</p> <p>The police officer who brought client C back to the home indicated he received a call at 7:55 PM. He was called to a state trooper's residence where client C had just walked into the home through the front door and was detained. The officer indicated client C told him that an old staff had been kidnapped by police and he went to save her. The officer indicated client C had also entered another home prior to entering the state trooper's home. The officer indicated one staff (did not specify) told him she was supposed to do 15 minute checks but did not do them.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/30/2012	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460			
(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			
	<p>The officer indicated neither staff knew he had left the group home.</p> <p>The conclusion of the investigation indicated, "There is evidence to support the fact that [client C] eloped from his residence. There is evidence to support that [staff #10] did not actually see [client C] to confirm he was in his bedroom and going to come down for his medications and did not follow [client C's] plan as written. There is evidence to support that [staff #5] did follow [client C's] plan as written."</p> <p>-On 11/21/11 at 7:53 AM, client C "...reportedly eloped" from his residence...". Client C, prior to the incident, told staff he was going to get his shoes from his room. When staff went to check on him 5-10 minutes later, client C was not located. The staff searched the group home and then contacted police when he was not found. Client C was later found sleeping under a desk in the upstairs office at 9:45 AM. The conclusion of the investigation indicated, "It has not been determined how long exactly and if and when [client C] left his residence."</p> <p>A review of the facility's Operating Practices - Supervised Group Living Services, dated April 2011, was</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460
---	---

(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
	<p>conducted on 4/27/12 at 10:00 AM. The policy indicated, "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... o. The following actions are prohibited by employees of Indiana MENTOR: 1) abuse, neglect, exploitation or mistreatment of an individual including misuse of an individual's funds. 2) violation of an individual's rights."</p> <p>An interview with Administrative Staff (AS) #1 on 4/30/12 at 4/30/12 at 2:29 PM. AS #1 indicated the facility should prevent abuse and neglect of the clients. AS #1 indicated staff falling asleep was neglect. AS #1 indicated staff not implementing client E's fall plan was neglect. AS #1 indicated staff not implementing client C's elopement plan was neglect.</p> <p>This federal tag relates to Complaint #IN00106828.</p> <p>9-3-2(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/30/2012	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460			
(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			
W0154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 5 of 23 incident/investigative reports reviewed affecting clients A, B, C, D, E, F, G and H, the facility failed conduct thorough investigations.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 4/27/12 at 10:40 AM.</p> <p>-On 4/4/12 at 6:30 PM, client D "wandered away" from the group home while two staff were working (staff #5 and #8). An interview with Administrative staff (AS) #1, included in the investigation, indicated a previous staff member observed client D walking outside by the group home. The former staff picked him up and brought him back to the home.</p> <p>An interview with staff #8 included in the investigation indicated while she and staff #5 were assisting client E into the home due to his unsteadiness, client D got up off the couch and went outside. Staff #8 indicated she kept client D in line of sight except for less than one minute while she</p>	W0154	<p>The Program Director was retrained on completing thorough investigations to clarify and include all findings and to include corrective measures needed on 5/17/2012 by the Quality Assurance Specialist. The Area Director and Quality Assurance Specialist will review all investigations for 90 days for thoroughness and then the Area Director will review further investigations on an on-going basis. Staff Responsible: Program Director, Area Director, Quality Assurance Specialist</p>	05/30/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/30/2012
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460		
(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	
	<p>assisted client E to the couch. Staff #8 then went outside to get client D who was on the sidewalk about 2 houses down from his house. Staff #8 indicated client D returned to the home after approximately 5 minutes of prompting. Staff #8 did not indicate a former staff member picked up client D nor was it addressed in the investigation.</p> <p>An interview with staff #5 included in the investigation indicated she and staff #8 were assisting client E into the home due to his issues with walking. Staff #5 indicated staff #8 was keeping client D within line of sight. Staff #8 observed client D walking off the porch; staff #8 went to get client D as soon as she assisted client E to sit on the couch. Staff #5 indicated client D returned to the home after about 5 minutes.</p> <p>The conclusion of the investigation indicated, "There is evidence to support that [client D] had wandered away from the group home premises for approximately five minutes. There is also evidence to support that [client D] was in line of sight for approximately four out of the five minutes." The investigation did not address the conflicting information on how client D returned to the home. There was no documentation indicating whether or not corrective action was taken with</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/30/2012
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460		
(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	
	<p>the staff or addressing the staff to client ratio at the time of the incident. There was no documentation an interview was conducted or attempted with the former staff.</p> <p>-On 3/2/12 at 8:30 AM, client E arrived to workshop unassisted, without his cane. While attempting to sit in a chair, client E fell backward and hit the left side of his head and left hand. He developed a raise lump on the back of his head and he was sent home. At 12:45 PM, group home staff transported client E to the hospital; no apparent injuries noted. A gait belt was implemented following the fall. There was no documentation an investigation was conducted.</p> <p>-On 12/27/11 at 6:00 PM, client B threw a fork hitting client G on the left temple. Client G's temple had 4 prong marks and was bleeding. Client G was treated at the home with first aid. The conclusion of the investigation indicated, "[Client B] had a behavior and threw a fork at [client G]. Staff followed his behavior plan appropriately." The investigation did not contain interviews from all the clients present at the time of the incident (the investigation did not indicate who was present during the incident). The investigation did not address that there was only one staff in the dining room at</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460
---	---

(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
	<p>the time of the incident. Administrative staff reviewed the results of the investigation on 1/9/12.</p> <p>-On 12/6/11 at 7:45 PM, client C eloped from the group home. The investigation indicated, "[Client C] has a history of elopement which is addressed in his behavior plan." Two staff were working at the time of the incident (staff #5 and #10).</p> <p>A review of client C's record was conducted on 4/30/12 at 10:22 AM. Client C's Behavior Development Program, dated 12/28/11, indicated he had a targeted behavior of elopement (vacating). Vacating will be defined to occur only at times when [client C's] is scheduled to be in to a specified environment (e.g., group home, day program) as outlined within [client C's] program plan. Vacating is defined as leaving without informing staff or leaving a program area and not returning when called. The plan indicated, "In inclement weather, keep protective clothing for staff and [client C] near the door so that it is easily available if [client C] exits the home. Alarms are installed on the doors in the home; staff should insure that they are working at the beginning of every shift. 1. Instead of directing [client C] to cease the behavior or to come back,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/30/2012	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460			
(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			
	<p>approach him by asking him where he is going. 2. Regardless of whether [client C] responds, tell [client C] that you will go with him. Do not talk with [client C], just stay with him. Do not chase [client C]; shadow him from behind. 3. About once every 5 minutes, ask [client C] if he is ready to return. 4. Stay with [client C] until he has returned to a safe location and keep him under observation until you are sure he will not vacate again."</p> <p>Staff #5 indicated in her interview in the investigation when she arrived for work at 6:00 PM, the door alarms were not functioning.</p> <p>Staff #10 indicated, in the facility's investigation, when she arrived for work (no time documented) the door alarms were not functioning and did not know staff were to complete 15 minutes checks due to the door alarms not functioning. Staff #10 indicated she did not complete 15 minute checks. At 7:45 PM, staff went upstairs to prompt client C for his evening medications; the investigation revealed the staff who went upstairs did not open client C's locked door or get a response from client C. At approximately 7:50 PM or 7:55 PM, the group home received a call from police asking if they were missing a client. The police brought client C back to the group home "shortly</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
--------------------	--	---------------	---	----------------------

	<p>after" 8:00 PM.</p> <p>An interview, included in the investigation, with the police officer who brought client C back to the home indicated he received a call at 7:55 PM. He was called to a state trooper's residence where client C had just walked into the home through the front door and was detained. The officer indicated client C told him that an old staff had been kidnapped by police and he went to save her. The officer indicated client C had also entered another home prior to entering the state trooper's home. The officer indicated one staff (did not specify) told him she was supposed to do 15 minute checks but did not do them. The officer indicated neither staff knew he had left the group home.</p> <p>The conclusion of the investigation indicated, "There is evidence to support the fact that [client C] eloped from his residence. There is evidence to support that [staff #10] did not actually see [client C] to confirm he was in his bedroom and going to come down for his medications and did not follow [client C's] plan as written. There is evidence to support that [staff #5] did follow [client C's] plan as written." The investigation did not address whether or not the staff to client ratio at the time of the incident was</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/30/2012	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460			
(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			
	<p>appropriate.</p> <p>-On 11/21/11 at 7:53 AM, client C "...reportedly eloped" from his residence...". Client C, prior to the incident, told staff #3 he was going to get his shoes from his room. Staff #12 was working on 11/21/11 but left work at approximately 7:30 -7:45 AM according to staff #3's statement. Staff #3 indicated staff #12 left work prior to her realizing client C was missing. When staff #3 went to check on him 5-10 minutes later, client C was not located. Staff #3 searched the group home and then contacted police when he was not found. Client C was later found sleeping under a desk in the upstairs office at 9:45 AM. The conclusion of the investigation indicated, "It has not been determined how long exactly and if and when [client C] left his residence." The investigation indicated an interview with staff #12 was not conducted ("attempted to contact, but was unsuccessful"). The investigation did not address there was one staff working at the time of the incident.</p> <p>An interview with Administrative Staff (AS) #1 indicated the facility should conduct thorough investigations of abuse and neglect, addressing issues noted during the investigation and interviewing all pertinent staff and clients.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460
---	---

(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
	<p>This federal tag relates to Complaint #IN00106828.</p> <p>9-3-2(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/30/2012
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460		
(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	
W0156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>Based on record review and interview for 1 of 23 incident/investigative reports reviewed affecting clients B and G, the facility failed to ensure the results of the investigation were reported to the administrator within five working days of the incident.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 4/27/12 at 10:40 AM. On 12/27/11 at 6:00 PM, client B threw a fork hitting client G on the left temple. Client G's temple had 4 prong marks and was bleeding. The conclusion of the investigation indicated, "[Client B] had a behavior and threw a fork at [client G]. Staff followed his behavior plan appropriately." Administrative staff reviewed the results of the investigation on 1/9/12.</p> <p>An interview with Administrative Staff (AS) #2 was conducted on 4/27/12 at 12:19 PM. AS #2 indicated the results of investigations should be reported to</p>	W0156	<p>The Program Director was retrained on completing thorough investigations to clarify and include all findings and to include corrective measures needed on 5/17/2012 by the Quality Assurance Specialist. The Area Director and Quality Assurance Specialist will review all investigations for 90 days for thoroughness and then the Area Director will review further investigations on an on-going basis. The Program Director and Quality Assurance Specialist will ensure that all investigation findings are reported to Administrator within five working days of the date of the incident. Staff Responsible: Program Director, Area Director, Quality Assurance Specialist.</p>	05/30/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/30/2012
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460		
(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	
	administrative staff within five working days of the incident. 9-3-2(a)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/30/2012	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460			
(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			
W0186	<p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on observation, interview and record review for 7 of 7 clients living in the group home (A, B, C, D, E, F and G), the facility failed to deploy staff appropriately to meet the needs of the clients.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 4/27/12 from 6:20 AM to 7:54 AM. From 6:20 AM to 6:30 AM, there were two staff working in the home (#1 and #3). At 6:30 AM, staff #7 arrived to work. At 7:02 AM, staff #1 left the group home leaving staff #3 and #7 to supervise clients A, B, C, D, E, F and G. At 6:43 AM, there was a strong smell of urine coming from client G's bedroom. At 6:56 AM, staff #7 put bowls on the table for breakfast; client F was given a bowl with cereal. At 6:56 AM, staff #7 served toast to A and F. Client D was noted to eat his toast quickly. At 6:57 AM, client D finished his piece of toast in</p>	W0186	<p>The schedule for this house has been modified so there are sufficient staff on duty for the morning shift and evening shifts in this home to meet the needs of the client. The Home Manager will monitor schedules to ensure there are sufficient staff for all shifts. The Program Director will review the weekly schedules to ensure the staffing is sufficient for the needs of the clients. Administrative staff that support this home were retrained on Abuse and Neglect policies, procedures and prevention on 5/18/2012. (See Attached) Staff in the home were retrained on the prevention of abuse and neglect of clients on 5/4/2012. Staff in the home were retrained on Active Treatment and following individual client's plans on 4/27/2012, 5/4/2012, and 5/11/2012. Staff in the home were retrained on a review of client protocols, dining plans to follow to prevent choking, and Client E's updated fall protocol with all equipment to keep him safe on 5/1/2012. (See</p>	05/30/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/30/2012	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460			
(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			
	4 bites; there was no staff sitting at the table to prompt client D to slow down. At 6:58 AM, there was no staff in the dining room for 15 seconds. Client F drank his lemonade in gulps, all at one time. Staff #3 entered the dining room and stood by client D. At 7:02 AM, staff #1 left the home. Client E was eating quickly with no prompts from staff to slow down. Client E then spilled his cereal and staff #3 cleaned it off the table. Client E had milk on his pants however he was not assisted by staff to change his clothes. At 7:05 AM, staff #3 left the dining room to administer client F's medications; there was one staff in the dining room. At 7:15 AM, client D attempted to drink from client B's cup however it was empty; there was no staff in the dining room with client D. Staff #7 assisted client E to the kitchen holding onto his gait belt. At 7:17 AM, clients C, D and G were left unsupervised at the dining room table. At 7:25 AM, a client visiting the group home for possible placement was outside on the front porch smoking a cigar; both staff were inside the home and not supervising the client. At 7:45 AM, the smell of urine coming from client D's bedroom was a large puddle of urine on the floor and in his bed, soaking his sheets. Staff did not clean up the urine from when initially noted at 6:43 AM. At 7:47 AM, the clients were assisted onto the van.		Attached)Observations have been completed by Administrative Staff, and will continue to be completed, to ensure that the trainings provided are being implemented for client safety.Staff Responsible: Home Manger, Program Director, Area Director, Quality Assurance Specialist, Nurse.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/30/2012	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460			
(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			
	<p>A review of the facility's incident/investigative reports was conducted on 4/27/12 at 10:40 AM.</p> <p>-On 4/6/12 at 5:00 PM, client E went outside to sit on the front porch to smoke. Staff #4 assisted client E to get outside and sitting in a chair. Another client's guardian, who was visiting the home, called out to staff #4 to come inside for a minute. As staff #4 went back outside, she observed client E trying to get up from the chair. Client E's walker slipped out from under him and he fell backward onto his bottom, hitting his head on the ground. Taken to hospital with tests indicating normal results with the exception of a couple of minor scrapes and scratches (no details of injuries). The conclusion of the investigation indicated, "There is evidence to support that [client E] had fallen causing him to hit his head. There is evidence to support that staff were NOT side by side with [client E] at the time of the fall. There is evidence to support that staff followed aspects of [client E's] fall protocol."</p> <p>A review of client E's fall protocol was conducted on 4/27/12 at 11:13 AM. The protocol, dated 4/20/12, indicated the following, "[Client E] has been diagnosed with Vertigo, becomes dizzy, loses his balance, at times has difficulty walking,</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460
---	---

(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
	<p>and has had recent falls... [Client E] will wear a helmet when standing/walking/ambulating, will have a gait belt, no further than arm's length away, will use chair alarm only when in recliner in his room, and will use bed alarm when in bed. When out of bed, [client E] needs to be in line of sight, with the following exceptions - when in recliner in his room and chair alarm turned on, when using bathroom (except staff assist with bathing) or having his private time in bathroom, but staff will give [client E] a bell and instruct him to ring when finished each time." The plan indicated, "[Client E] to always wear helmet and gait belt. Always standby assist from staff with hand on gait belt, staff to stand slightly behind [client E] on his right and have their left hand on the gait belt on [client E's] left back side."</p> <p>A review of client E's fall protocol was conducted on 4/30/12 at 2:53 PM. The protocol, dated 3/2/12, indicated the following, "[Client E] is to wear a gait belt from the time he gets up in the morning until he goes to bed at night, and if he gets up during the night. Staff are to be at [client E's] side at all times when he is up ambulating or when he transfers. Staff are to be 1 on 1 (one on one staffing) with [client E] and [client E] is to have 'NO FALLS' as staff are to be at</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	<p>his side at all times when transferring or ambulating... THERE ARE NO EXCEPTIONS TO ABOVE INSTRUCTIONS."</p> <p>-On 4/4/12 at 6:30 PM, client D "wandered away" from the group home while two staff were working (staff #5 and #8). An interview with Administrative staff (AS) #1, included in the investigation, indicated a previous staff member observed client D walking outside by the group home. The former staff picked him up and brought him back to the home.</p> <p>An interview with staff #8 included in the investigation indicated while she and staff #5 were assisting client E into the home due to his unsteadiness, client D got up off the couch and went outside. Staff #8 indicated she kept client D in line of sight except for less than one minutes while she assisted client E to the couch. Staff #8 then went outside to get client D who was on the sidewalk about 2 houses down from his house. Staff #8 indicated client D returned to the home after approximately 5 minutes of prompting. Staff #8 did not indicate a former staff member picked up client D nor was it addressed in the investigation.</p> <p>An interview with staff #5 included in the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/30/2012	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460			
(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			
	<p>investigation indicated she and staff #8 were assisting client E into the home due to his issues with walking. Staff #5 indicated staff #8 was keeping client D within line of sight. Staff #8 observed client D walking off the porch; staff #8 went to get client D as soon as she assisted client E to sit on the couch. Staff #5 indicated client D returned to the home after about 5 minutes.</p> <p>The conclusion of the investigation indicated, "There is evidence to support that [client D] had wandered away from the group home premises for approximately five minutes. There is also evidence to support that [client D] was in line of sight for approximately four out of the five minutes." The investigation did not address the conflicting information on how client D returned to the home. There was no documentation indicating whether or not corrective action was taken with the staff or addressing the staff to client ratio at the time of the incident.</p> <p>-On 12/27/11 at 6:00 PM, client B threw a fork hitting client G on the left temple. Client G's temple had 4 prong marks and was bleeding. Client G was treated at the home with first aid. The conclusion of the investigation indicated, "[Client B] had a behavior and threw a fork at [client G]. Staff followed his behavior plan</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460
---	---

(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
	<p>appropriately." The investigation did not contain interviews from all the clients present at the time of the incident (the investigation did not indicate who was present during the incident). The investigation did not address that there was only one staff in the dining room at the time of the incident; staff #1 indicated in his statement he was in the kitchen at the time of the incident. The investigation indicated two staff (#1 and #7) were working at the time of the incident.</p> <p>-On 12/6/11 at 7:45 PM, client C eloped from the group home. The investigation indicated, "[Client C] has a history of elopement which is addressed in his behavior plan." Two staff were working at the time of the incident (staff #5 and #10).</p> <p>A review of client C's record was conducted on 4/30/12 at 10:22 AM. Client C's Behavior Development Program, dated 12/28/11, indicated he had a targeted behavior of elopement (vacating). Vacating will be defined to occur only at times when [client C's] is scheduled to be in to a specified environment (e.g., group home, day program) as outlined within [client C's] program plan. Vacating is defined as leaving without informing staff or leaving</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460
---	---

(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
	<p>a program area and not returning when called. The plan indicated, "In inclement weather, keep protective clothing for staff and [client C] near the door so that it is easily available if [client C] exits the home. Alarms are installed on the doors in the home; staff should insure that they are working at the beginning of every shift. 1. Instead of directing [client C] to cease the behavior or to come back, approach him by asking him where he is going. 2. Regardless of whether [client C] responds, tell [client C] that you will go with him. Do not talk with [client C], just stay with him. Do not chase [client C]; shadow him from behind. 3. About once every 5 minutes, ask [client C] if he is ready to return. 4. Stay with [client C] until he has returned to a safe location and keep him under observation until you are sure he will not vacate again."</p> <p>Staff #5 indicated in her interview in the investigation when she arrived for work at 6:00 PM, the door alarms were not functioning.</p> <p>Staff #10 indicated in her interview in the investigation when she arrived for work (no time documented) the door alarms were not functioning and did not know staff were to complete 15 minutes checks due to the door alarms not functioning. Staff #10 indicated she did not complete</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460
---	---

(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
	<p>15 minute checks. At 7:45 PM, staff went upstairs to prompt client C for his evening medications; the investigation revealed the staff who went upstairs did not open client C's locked door or get a response from client C. At approximately 7:50 PM or 7:55 PM, the group home received a call from police asking if they were missing a client. The police brought client C back to the group home "shortly after" 8:00 PM.</p> <p>The police officer who brought client C back to the home indicated he received a call at 7:55 PM. He was called to a state trooper's residence where client C had just walked into the home through the front door and was detained. The officer indicated client C told him that an old staff had been kidnapped by police and he went to save her. The officer indicated client C had also entered another home prior to entering the state trooper's home. The officer indicated one staff (did not specify) who told him she was supposed to do 15 minute checks but did not do them. The officer indicated neither staff knew he had left the group home.</p> <p>The conclusion of the investigation indicated, "There is evidence to support the fact that [client C] eloped from his residence. There is evidence to support that [staff #10] did not actually see [client</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/30/2012	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460			
(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			
	<p>C] to confirm he was in his bedroom and going to come down for medications and did not follow [client C's] plan as written. There is evidence to support that [staff #5] did follow [client C's] plan as written."</p> <p>-On 11/21/11 at 7:53 AM, client C "...reportedly eloped" from his residence...". Client C, prior to the incident, told staff #3 he was going to get his shoes from his room. Staff #12 was working on 11/21/11 but left work at approximately 7:30 -7:45 AM according to staff #3's statement. Staff #3 indicated staff #12 left work prior to her realizing client C was missing. When staff #3 went to check on him 5-10 minutes later, client C was not located. Staff #3 searched the group home and then contacted police when he was not found. Client C was later found sleeping under a desk in the upstairs office at 9:45 AM. The conclusion of the investigation indicated, "It has not been determined how long exactly and if and when [client C] left his residence."</p> <p>A review of client F's Dining Plan, dated 1/20/12, was conducted on 4/27/12 at 1:19 PM. Client F's plan indicated, "...will drink (any size) all at one time. Often he will get choked or cough when doing this. Staff to assist [client F] in</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/30/2012
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460		
(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	
	<p>taking small drinks of fluids ad taking a breath between drinks. Staff to sit beside [client F] on his right during meals to monitor food seeking behaviors with dominant hand."</p> <p>A review of client E's Dining Plan, dated 1/20/12, was conducted on 4/27/12 at 1:19 PM. Client E's plan indicated, "Staff to remind/encourage [client E] to slow down when eating."</p> <p>A review of client D's Dining Plan, dated 1/20/12, was conducted on 4/27/12 at 1:19 PM. Client D's plan indicated, "Staff to sit beside [client D] to assist to eat slowly as needed. Hand over hand assist as needed. Staff to encourage to take drink between bites of food and praise when he does." The plan indicated he had a diagnosis of dysphasia.</p> <p>A review of client A's Dining Plan, dated 1/20/12, was conducted on 4/27/12 at 1:19 PM. Client A's plan indicated, "staff to sit beside [client A] to assist to eat slowly as needed. Hand over hand assist as needed."</p> <p>An interview with the Home Manager (HM) was conducted on 4/27/12 at 12:49 PM. The HM indicated there should be three staff working in the home.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	<p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 4/27/12 at 12:33 PM. The QMRP indicated there should be three staff working in the home. The QMRP indicated it made a huge difference when three staff were not working in the home. The QMRP stated it was easier to "manage" with three staff.</p> <p>An interview with Administrative Staff (AS #1) was conducted on 4/27/12 at 12:35 PM. AS #1 indicated there should be three staff working in the home.</p> <p>This federal tag relates to Complaint #IN00106828.</p> <p>9-3-3(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460
---	---

(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
W0249	<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, interview and record review for 4 of 7 clients living in the group home, the facility failed to ensure their program plans were implemented as written.</p> <p>Findings include:</p> <p>1) An observation was conducted at the group home on 4/27/12 from 6:20 AM to 7:54 AM. At 6:36 AM, client E was assisted by staff #1 to the shower. Staff #1 held onto client E's gait belt while client E used his walker. Staff #1 was carrying client E's helmet. At 7:15 AM, when client E finished with breakfast, he indicated he was finished. Staff #7 held onto his gait belt to assist him into the kitchen. Client E did not use his walker or receive prompts to use his walker. At 7:32 AM, client E exited the restroom with staff #7 holding onto his gait belt. Client E was not using his walker.</p> <p>A review of client E's fall protocol was conducted on 4/27/12 at 11:13 AM. The</p>	W0249	<p>Administrative staff that support this home were retrained on Abuse and Neglect policies, procedures and prevention on 5/18/2012. (See attached)Staff in the home were retrained on the prevention of abuse and neglect of clients on 5/4/2012.Staff in the home were retrained on Active Treatment and following individual client's plans on 4/27/2012, 5/4/2012, and 5/11/2012.Staff in the home were retrained on a review of client protocols, dining plans to follow to prevent choking, and Client E's updated fall protocol with all equipment to keep him safe on 5/1/2012. (See Attached)Observations have been completed by Administrative Staff, and will continue to be completed, to ensure that thetrainings provided are being implemented for client safety.Staff Responsible: Home Manager, Program Director, Area Director, Quality Assurance Specialist, Nurse.</p>	05/30/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460
---	---

(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
	<p>protocol, dated 4/20/12, indicated the following, "[Client E] has been diagnosed with Vertigo, becomes dizzy, loses his balance, at times has difficulty walking, and has had recent falls... [Client E] will wear a helmet when standing/walking/ambulating, will have a gait belt, no further than arm's length away, will use chair alarm only when in recliner in his room, and will use bed alarm when in bed. When out of bed, [client E] needs to be in line of sight, with the following exceptions - when in recliner in his room and chair alarm turned on, when using bathroom (except staff assist with bathing) or having his private time in bathroom, but staff will give [client E] a bell and instruct him to ring when finished each time." The plan indicated, "[Client E] to always wear helmet and gait belt. Always standby assist from staff with hand on gait belt, staff to stand slightly behind [client E] on his right and have their left hand on the gait belt on [client E's] left back side."</p> <p>An interview with the home manager (HM) was conducted on 4/27/12 at 12:49 PM. The HM indicated client E should be wearing his helmet when he was ambulating.</p> <p>An interview with the Administrative Staff (AS) #1 was conducted on 4/27/12</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/30/2012	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460			
(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			
	<p>at 12:35 PM. AS #1 indicated client E's helmet should be on his head when client E was ambulating.</p> <p>An interview with the nurse was conducted on 4/27/12 at 10:06 AM. The nurse indicated client E should be wearing his helmet when he is ambulating.</p> <p>2) An observation was conducted at the group home on 4/27/12 from 6:20 AM to 7:54 AM. At 6:56 AM, client D was eating his toast quickly. He finished his toast in 4 bites, at 6:57 AM, with no prompts from staff #3 or #7 to slow down or to take drinks between bites. At 6:58 AM, neither staff was in the dining room for 15 seconds. Client F drank all of his lemonade in several successive drinks, without stopping or being prompted to slow down. Staff #3 returned to the dining room and stood by client D. At 7:00 AM, staff #3 poured client D's cereal; he ate it dry. Client D was not prompted to take drinks between bites or to slow down while eating his cereal. At 7:02 AM, client E was eating quickly with no prompts from staff to slow down. At 7:05 AM and 7:08 AM, client D continued to eat dry cereal with no prompting from staff to slow down or to take drinks between bites; staff did not sit next to him. At 7:10 AM, client D was</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/30/2012	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460			
(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			
	<p>prompted to slow down; he was not prompted by staff #3 to take drinks between bites. At 7:17 AM, clients C, D and G were left at the table unsupervised for 30 seconds. At 7:18 AM while staff were not in the dining room, client D poured his own juice and then drank it in 6 gulps without a break; staff returned as he was gulping his juice but did not prompt him to slow down. During breakfast, the two staff did not sit down during the meal.</p> <p>A review of client F's Dining Plan, dated 1/20/12, was conducted on 4/27/12 at 1:19 PM. Client F's plan indicated, "...will drink (any size) all at one time. Often he will get choked or cough when doing this. Staff to assist [client F] in taking small drinks of fluids ad taking a breath between drinks. Staff to sit beside [client F] on his right during meals to monitor food seeking behaviors with dominant hand."</p> <p>A review of client E's Dining Plan, dated 1/20/12, was conducted on 4/27/12 at 1:19 PM. Client E's plan indicated, "Staff to remind/encourage [client E] to slow down when eating."</p> <p>A review of client D's Dining Plan, dated 1/20/12, was conducted on 4/27/12 at 1:19 PM. Client D's plan indicated, "Staff</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/30/2012	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460			
(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			
	<p>to sit beside [client D] to assist to eat slowly as needed. Hand over hand assist as needed. Staff to encourage to take drink between bites of food and praise when he does." The plan indicated he had a diagnosis of dysphasia.</p> <p>A review of client A's Dining Plan, dated 1/20/12, was conducted on 4/27/12 at 1:19 PM. Client A's plan indicated, "staff to sit beside [client A] to assist to eat slowly as needed. Hand over hand assist as needed."</p> <p>An interview with the Home Manager (HM) was conducted on 4/27/12 at 12:49 PM. The HM indicated the clients' dining plans should be implemented as written.</p> <p>An interview with the nurse was conducted on 4/27/12 at 10:06 AM. The nurse indicated the staff should implement the clients' dining plans as written.</p> <p>An interview with Administrative Staff (AS #1) was conducted on 4/27/12 at 12:35 PM. AS #1 indicated the staff should implement the clients' dining plans as written.</p> <p>9-3-4(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/30/2012	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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			
W0488	<p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation and interview for 6 of 7 clients living in the group home (A, B, C, D, E, and F), the facility failed to ensure the clients prepared their breakfast, served themselves and participated in the clean-up from breakfast.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 4/27/12 from 6:20 AM to 7:54 AM. At 6:53 AM, staff #7 was making toast in the kitchen. Clients B, C and a visiting client were in the kitchen and available to assist but were not prompted to do so. Staff #7 put margarine and jelly on the toast without prompting the clients to assist. At 6:56 AM, staff #7 passed out bowls onto the dining room table; staff #7 did not prompt the clients to assist. Staff #7 gave client F a bowl with cereal already poured into it. Staff #7 then carried around a plate with toast on it serving it to client A and F. At 7:00 AM, staff #3 poured client D's cereal with no prompts for client D to assist. At 7:04 AM after client E spilled his cereal and staff #3 cleaned it up and then poured client E another bowl of cereal. Staff #3 then poured milk onto client E's cereal.</p>	W0488	<p>Staff in the home were retrained on Active Treatment and following individual client's plans on 4/27/2012, 5/4/2012, and 5/11/12. Staff in the home were retrained on a review of client protocols, dining plans to follow to prevent choking, and Client E's updated fall protocol with all equipment to keep him safe on 5/1/2012. (See Attached) Observations have been completed by Administrative Staff, and will continue to be completed, to ensure that the trainings provided are being implemented for client safety. Staff Responsible: Home Manager, Program Director, Area Director, Quality Assurance Specialist, Nurse.</p>	05/30/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460
---	---

(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
	<p>At 7:05 AM, staff #7 brought client E toast. At 7:10 AM, staff #7 poured client D another bowl of cereal after he picked up the cereal container. At 7:37 AM, staff #7 was in the kitchen unloading clean dishes from the dishwasher. Staff #7 then loaded the dishwasher with the dirty breakfast dishes. Staff #7 did not prompt the clients to assist.</p> <p>An interview with the Home Manager (HM) was conducted on 4/27/12 at 12:49 PM. The HM indicated the clients should be involved with meal prep and clean-up as much as possible. The HM indicated the clients should serve themselves to the extent they were able to. The clients should be assisted if necessary to participate in meal prep, clean-up and serving themselves.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 4/27/12 at 12:35 PM. AS #1 indicated the clients should be involved in meal prep, clean-up and serving themselves.</p> <p>9-3-8(a)</p>			