

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G300	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/30/2012
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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151
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W0000	<p>This visit was for the investigation of complaint #IN00117382.</p> <p>Complaint #IN00117382 - Substantiated, Federal/state deficiencies related to the allegation are cited at W149 and W240.</p> <p>Unrelated deficiencies cited.</p> <p>Survey dates: October 29 and 30, 2012.</p> <p>Facility Number: 000819 Provider Number: 15G300 AIM Number: 100249100</p> <p>Surveyor: Steven Schwing, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Qaulity Review was completed on 11/2/12 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.

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W0104	<p>483.410(a)(1) GOVERNING BODY 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 (A, B, C, D, E, F, G and H), the governing body failed to ensure repairs to holes in the walls were repainted and the walls in the living room were repainted after the ceiling was replaced.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 10/29/12 from 2:42 PM to 5:19 PM. During the observations at the group home, there were numerous patched holes in the wall that had not been painted. The living room ceiling had been replaced however the walls next to the ceiling were a different color.</p> <p>An interview with the Program Director (PD) was conducted on 10/30/12 at 11:31 AM. The PD indicated there were several holes that had been repaired but not repainted. The PD indicated the walls in the living room needed to be repainted since the ceiling was replaced but the walls had not been repainted.</p> <p>9-3-1(a)</p>	W0104	<p>All holes in the walls were repainted on 11/6/2012. The living room walls were also repainted on this date. TSI will ensure that all home repairs are completed in a timely manner. All work orders will be entered on log sheets upon the receiving. The Area Director and Maintenance Supervisor will review work order logs weekly to ensure that all work orders have been completed. Party responsible: Area Director, Program Director and Maintenance Supervisor</p>	11/30/2012			

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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. Based on record review and interview for 11 of 45 incident/investigative reports reviewed affecting 4 of 8 clients living in the group home (B, E, F and H), the facility neglected to implement its policies and procedures to prevent abuse and neglect of the clients.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 10/29/12 at 12:00 PM.</p> <p>1) On 8/18/12 at 11:00 AM, client B hit client H in the face after client H rested his arms on client B's seat. Client H was not injured. The investigative report's Brief Summary indicated, incorrectly, "[Client H] threw a water bottle in the van during transport that hit [client G] in the shoulder." The investigation did not include an interview with client E who was on the van at the time of the incident.</p> <p>2) On 8/20/12 at 5:15 PM, client F attempted to pull the electric outlet out of the wall in the living room. Staff attempted to redirect however client F punched staff. Staff implemented a</p>	W0149	All staff have been re-trained on client rights regarding the prevention of abuse, neglect and/or mistreatment. All staff have also been retrained on the prevention of client-to-client abuse. All staff were trained on safety precautions for agency approved Physical Intervention Alternatives (PIA). All staff were trained on reporting self-injurious behaviors to ensure that such incidents are reported to BDDS and investigated. The Program Director was retrained on submitting a BDDS report and completing an investigation when a client engages in self-injurious behavior. Responsible Parties: Area Director, Program Director, Home Manager and Direct Support Professionals.	11/30/2012			

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	<p>restraint on the floor for 30 minutes. The report indicated, "[Client F] was lying on his back during the physical hold." Client F was also administered a PRN (as needed) medication during the behavior. Client F cut his finger while trying to pull the outlet out of the wall requiring first aid.</p> <p>3) On 8/28/12 at 4:00 PM, client F was restrained by staff after physical aggression. The report indicated, "Staff on duty used agency approved methods to physically hold [client F] on the floor in an attempt to calm him. Prior to restraint, [client F] began obsessing and targeting staff's feet along with attempting to eat a tube of toothpaste, bending his fingers back to the point of pain, asking staff to bend his fingers back, and going after staff's fingers and trying to bend them back. [Client F] also began to kick, headbutt, and show other signs of physical aggression prior to the restraint and a bit during it. [Client F] was restrained on the floor of the group home however there were no other clients present and the hold in its entirety lasted approximately 20 minutes. The restraint did not appear to be effective considering that [client F] was administered his PRN for behavioral episodes after the restraint and 1 dosage of PRN medication was successful and effective in ceasing the</p>			

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	<p>behavior as a whole."</p> <p>4) On 9/15/12 at 9:30 PM, client B went downstairs and reported to staff he called client E a "bi---" and hit him in the back of the head. Client B indicated client E was in his bedroom while client B was out of the house. Client E was not injured. The investigative report's Brief Summary indicated, incorrectly, "[Client H] threw a water bottle in the van during transport that hit [client G] in the shoulder."</p> <p>5) On 9/16/12 at 10:00 PM, client F took some papers to his room per a Narrative Notes report dated 9/16/12. Staff #9 went to check on him and he had removed three toe nails (one on his left foot and two on his right foot). There was no Bureau of Developmental Disabilities Services (BDDS) report submitted. There was no investigation to review.</p> <p>6) On 10/2/12 at 2:50 PM, client F "aggressively" grabbed onto and bent staff's fingers. Staff attempted to redirect but was unsuccessful. Client F was administered a PRN. The investigation, dated 10/8/12, indicated, "On 10/2/12 [client F] began to engage in self-injurious behaviors evidenced by him aggressively bending his fingers backwards as well as biting his fingers.</p>						

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	<p>Both [staff #11 and #1] attempted to redirect [client F], but were unsuccessful. [Client F] began to grab and bend the staff member's fingers and was attempted to be redirected. [Staff #1 and #11] attempted to hold [client F's] hands down when [client F] became physically aggressive with [staff #1 and #11]. [Staff #1 and #11] physically restrained [client F] and called in [staff #10] and [staff #4] to assist. [Staff #12] later arrived to the home to assist. [Staff #13] was present at the home during the time of the incident. [Client F] was administered a PRN at 2:50 PM and restrained shortly after. [Client F] was administered a second, third and fourth PRN at 3:20 PM, 3:50 PM and 4:40 PM. [Client F] was physically restrained on his stomach due to staff being unable to restrain him on his back due to his continued aggression and his ability to lift the staff off of him. [Client F] was laughing throughout the incident. [Client F] continued to be physically aggressive with staff and was restrained for approximately three and a half hours. [Client F] was released once calm... Prior to the incident, [client F] was in the van and had been giving high fives to others. [Client F] suddenly began to aggressively grab onto and bend back [staff #11's] fingers." The conclusion of the investigation indicated, "There is evidence to support that [client F's]</p>			

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	<p>Behavior Plan was followed. There is evidence to support that staff physically restrained [client F] on his stomach and received Corrective Action as a result of the incident. There is evidence to support that [client F] had become physically aggressive with staff and was engaged in self-injurious behavior."</p> <p>7) On 10/5/12 at 4:00 PM, client F was bending his own and staff's fingers back. Client F grabbed, poked and pinched staff's arms and continued to escalate. Three PRNs were given at 4:00 PM, 5:45 PM and 6:25 PM. Client F was restrained for one hour.</p> <p>8) On 10/6/12 at 6:00 PM, client H reported that on 10/8/12 staff #15 showed him a picture of a pierced penis on the staff's cell phone. The facility terminated staff #15.</p> <p>9) On 10/9/12 at 7:45 PM, client H was upset client E was in his room playing video games with client H's roommate. Client H shut the door hitting client E in the shoulder area. Client H picked up a chair and threw it toward client E. Clients E and H then hit each other. Neither client was injured.</p> <p>10) On 10/22/12 at 7:00 PM, client B threw a plastic container at client E when</p>						

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	<p>client E made inappropriate comments to client B. Client E threw the container back. Neither client was injured.</p> <p>11) On 10/27/12 at 2:30 (no AM or PM noted), client F was at the table writing. The report indicated, "Client got up for no reason in the middle of writing and attempted to stab staff with pen. Then became combative non-stop trying to bite, kick, headbutt and claw." The report indicated a PRN and restraint were used. The facility did not provide documentation the incident was investigated.</p> <p>A review of the facility's abuse and neglect policy, dated April 2011, was conducted on 10/129/12 at 11:53 AM. The policy indicated the following, "Any allegation of abuse or human rights violation is thoroughly investigated by the Area Director in consultation with Human Resources Department and/or Quality Assurance/Risk Management Department." 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</p>			

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	<p>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 the Area Director (AD) was conducted on 10/29/12 at 12:20 PM. The AD indicated client F will grab for others' fingers; the AD indicated this was a known behavior. The AD indicated the investigations on 8/18/12 and 9/15/12 indicated incorrect information in the brief summary section. The AD indicated the investigations should have been updated to reflect the investigation being conducted. The AD indicated interviews should be attempted with all the clients present during an incident. At 1:14 PM, the AD indicated restraints should not be conducted if client on their stomach. The AD indicated a restraint should be used until the client was calm and attempted to be released when the client should signs of calming. The AD indicated he was aware of two staff being injured from client F's behavior, staff #11 and #14. The AD indicated neither staff work at the home anymore. The AD indicated both staff received training to release a hold of the fingers. The AD indicated staff should not allow a client to grab their fingers. The AD indicated client to client</p>						

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	<p>aggression was considered abuse and should be prevented. The AD indicated client to client aggression was prohibited and should not happen. The AD indicated the staff should remove other clients or protect the clients in the area when one client was upset. The AD indicated the staff should be with the client showing signs of agitation. The AD indicated there were "very few" incidents without signs of agitation prior to an incident occurring. The AD indicated the use of any restraints, including PRN use, should be investigated. On 10/30/12 at 11:31 AM, the AD indicated the incidents on 9/16/12 and 10/27/12 should have been investigated. The AD indicated the 9/16/12 incident should have been reported to BDDS.</p> <p>This federal tag relates to complaint #IN00117382.</p> <p>9-3-2(a)</p>			

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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 4 of 45 incident reports reviewed affecting clients B, E, F and H, the facility failed to conduct thorough investigations.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 10/29/12 at 12:00 PM.</p> <p>1) On 8/18/12 at 11:00 AM, client B hit client H in the face after client H rested his arms on client B's seat. Client H was not injured. The investigative report's Brief Summary indicated, incorrectly, "[Client H] threw a water bottle in the van during transport that hit [client G] in the shoulder." The investigation did not include an interview with client E who was on the van at the time of the incident.</p> <p>2) On 9/15/12 at 9:30 PM, client B went downstairs and reported to staff he called client E a "bi---" and hit him in the back of the head. Client B indicated client E was in his bedroom while client B was out of the house. Client E was not injured. The investigative report's Brief Summary indicated, incorrectly, "[Client</p>	W0154	<p>The Program Director was re-trained on completing thorough investigations and what types of events will require an investigation.</p> <p>Responsible Parties: Area Director, Program Director and Quality Assurance</p>	11/30/2012			

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	<p>H] threw a water bottle in the van during transport that hit [client G] in the shoulder."</p> <p>3) On 9/16/12 at 10:00 PM, client F took some papers to his room per a Narrative Notes report dated 9/16/12. Staff #9 went to check on him and he had removed three toe nails (one on his left foot and two on his right foot). There was no Bureau of Developmental Disabilities Services (BDDS) report submitted. There was no investigation to review.</p> <p>4) On 10/27/12 at 2:30 (no AM or PM noted), client F was at the table writing. The report indicated, "Client got up for no reason in the middle of writing and attempted to stab staff with pen. Then became combative non-stop trying to bite, kick, headbutt and claw." The report indicated a PRN and restraint were used. The facility did not provide documentation the incident was investigated.</p> <p>An interview with the Area Director (AD) was conducted on 10/29/12 at 12:20 PM. The AD indicated the investigations on 8/18/12 and 9/15/12 indicated incorrect information in the brief summary section. The AD indicated the investigations should have been updated to reflect the investigation being conducted. The AD</p>						

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	<p>indicated interviews should be attempted with all the clients present during an incident. The AD indicated the use of any restraints, including PRN use, should be investigated. On 10/30/12 at 11:31 AM, the AD indicated the incidents on 9/16/12 and 10/27/12 should have been investigated.</p> <p>9-3-2(a)</p>				

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W0240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on record review and interview for 1 of 4 clients in the sample (F), the facility failed to ensure client F's behavior plan (BSP) was updated to reflect changes in his behavior and the type of restraint to use was documented in the plan.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 10/29/12 at 12:00 PM.</p> <p>1) On 8/20/12 at 5:15 PM, client F attempted to pull the electric outlet out of the wall in the living room. Staff attempted to redirect however client F punched staff. Staff implemented a restraint on the floor for 30 minutes. The report indicated, "[Client F] was lying on his back during the physical hold." Client F was also administered a PRN (as needed) medication during the behavior. Client F cut his finger while trying to pull the outlet out of the wall requiring first aid.</p> <p>2) On 8/28/12 at 4:00 PM, client F was restrained by staff after physical aggression. The report indicated, "Staff</p>	W0240	<p>The Inter Disciplinary Team (IDT) has met to review the changes needed for Client F's Behavior Plan. Client F's Behavior Plan is in the process of being revised. Once the revisions have taken place, the IDT will review. Guardian and HRC approval will be obtained. Upon Guardian and HRC approval, staff will be trained on Client F's new Behavior Plan. The new plan will then be implemented. The Behavior Plan will be revised as necessary to reflect changes in Client F's behavior. Responsible Parties: Area Director, Program Director, Home Manager and Behavior Specialist</p>	11/30/2012			

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	<p>on duty used agency approved methods to physically hold [client F] on the floor in an attempt to calm him. Prior to restraint, [client F] began obsessing and targeting staff's feet along with attempting to eat a tube of toothpaste, bending his fingers back to the point of pain, asking staff to bend his fingers back, and going after staff's fingers and trying to bend them back. [Client F] also began to kick, headbutt, and show other signs of physical aggression prior to the restraint and a bit during it. [Client F] was restrained on the floor of the group home however there were no other clients present and the hold in its entirety lasted approximately 20 minutes. The restraint did not appear to be effective considering that [client F] was administered his PRN for behavioral episodes after the restraint and 1 dosage of PRN medication was successful and effective in ceasing the behavior as a whole."</p> <p>3) On 9/16/12 at 10:00 PM, client F took some papers to his room per a Narrative Notes report dated 9/16/12. Staff #9 went to check on him and he had removed three toe nails (one on his left foot and two on his right foot).</p> <p>4) On 10/2/12 at 2:50 PM, client F "aggressively" grabbed onto and bent staff's fingers. Staff attempted to redirect</p>				

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	<p>but was unsuccessful. Client F was administered a PRN. The investigation, dated 10/8/12, indicated, "On 10/2/12 [client F] began to engage in self-injurious behaviors evidenced by him aggressively bending his fingers backwards as well as biting his fingers. Both [staff #11 and #1] attempted to redirect [client F], but were unsuccessful. [Client F] began to grab and bend the staff member's fingers and was attempted to be redirected. [Staff #1 and #11] attempted to hold [client F's] hands down when [client F] became physically aggressive with [staff #1 and #11]. [Staff #1 and #11] physically restrained [client F] and called in [staff #10] and [staff #4] to assist. [Staff #12] later arrived to the home to assist. [Staff #13] was present at the home during the time of the incident. [Client F] was administered a PRN at 2:50 PM and restrained shortly after. [Client F] was administered a second, third and fourth PRN at 3:20 PM, 3:50 PM and 4:40 PM. [Client F] was physically restrained on his stomach due to staff being unable to restrain him on his back due to his continued aggression and his ability to lift the staff off of him. [Client F] was laughing throughout the incident. [Client F] continued to be physically aggressive with staff and was restrained for approximately three and a half hours. [Client F] was released once</p>			

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	<p>calm... Prior to the incident, [client F] was in the van and had been giving high fives to others. [Client F] suddenly began to aggressively grab onto and bend back [staff #11's] fingers." The conclusion of the investigation indicated, "There is evidence to support that [client F's] Behavior Plan was followed. There is evidence to support that staff physically restrained [client F] on his stomach and received Corrective Action as a result of the incident. There is evidence to support that [client F] had become physically aggressive with staff and was engaged in self-injurious behavior."</p> <p>5) On 10/5/12 at 4:00 PM, client F was bending his own and staff's fingers back. Client F grabbed, poked and pinched staff's arms and continued to escalate. Three PRNs were given at 4:00 PM, 5:45 PM and 6:25 PM. Client F was restrained for one hour.</p> <p>6) On 10/27/12 at 2:30 (no AM or PM noted), client F was at the table writing. The report indicated, "Client got up for no reason in the middle of writing and attempted to stab staff with pen. Then became combative non-stop trying to bite, kick, headbutt and claw." The report indicated a PRN and restraint were used.</p> <p>A review of client F's BSP, dated 6/26/12,</p>			

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	<p>was conducted on 10/30/12 at 11:59 AM. The BSP indicated client F had a targeted behavior of physical assault (PA). PA was defined as "attempted or actual purposeful attacks directed at other people that may include striking, kicking, pulling hair, violently pulling clothing or glasses, biting or throwing objects." The BSP did not indicate client F may grab staff's fingers and bend them. The Responding to Targeted Behaviors section indicated for PA, "Direct him to stop the behavior. Remove potential targets from [client F's] vicinity. If he stops the behavior, go to step 3 below. If the assault continues, physically intervene. Get between [client F] and the target of the assault. Use the agency-approved crisis intervention blocking techniques. If blocking is ineffective, use the least restrictive agency-approved crisis intervention containment technique as needed to prevent further aggression. Separate [client F] from others and encourage him to engage in an MST (mood stability training) activity...".</p> <p>An interview with the home manager (HM) was conducted on 10/29/12 at 3:21 PM. The HM indicated the MST techniques listed in client F's BSP were causing client F to become more obsessed. The HM indicated the plan needed to be revised.</p>			

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	<p>An interview with the Behavior Consultant (BC) was conducted on 10/30/12 at 10:54 AM. The BC indicated client F's plan was not effective. The BC indicated the plan needed to be revised to increase the number of engaging activities to reduce physical aggression, PRN use and restraints. The BC indicated he was going to include new restraint guidelines with the types of restraints to use within the plan. The BC indicated the revised plan would include to eliminate given client F attention during restraints. The BC indicated client F needed to learn to communicate effectively. The BC stated the current plan was "generic" and the PRN included in the plan needed to be effective.</p> <p>An interview with the Program Director (PD) was conducted on 10/30/12 at 11:31 AM. The PD indicated some aspects of client F's current BSP were effective and some aspects needed improvement. The PD indicated the PRN protocol and restraints needed to be discussed and possibly revised.</p> <p>An interview with the Area Director (AD) was conducted on 10/30/12 at 11:31 AM. The AD indicated not all the steps on client F's plan were effective. The AD indicated the team was meeting on</p>						

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	<p>11/2/12 to discuss the PRN guidelines and restraints. The AD indicated the team may recommend the psychiatrist review client F's current medications.</p> <p>This federal tag relates to complaint #IN00117382.</p> <p>9-3-4(a)</p>				