

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G363	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/20/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 84 S WALNUT ST DANVILLE, IN 46122
---	---

(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 a fundamental recertification and state licensure survey.</p> <p>Survey dates: April 16, 17, 19, and 20, 2012.</p> <p>Facility number: 000877 Provider number: 15G363 AIMS number: 100244220</p> <p>Surveyor: Brenda Nunan, RN, CDDN, Public Health Nurse Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 4/30/12 by Ruth Shackelford, 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:  15G363		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/20/2012	
NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 84 S WALNUT ST DANVILLE, IN 46122			
(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			
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 interview and record review, the facility failed to implement their policy and procedures to conduct and complete investigations in 5 working days for 2 of 12 allegations of abuse/neglect (clients #1 and #5).</p> <p>Findings include:</p> <p>1. An Indiana Division of Disability and Rehabilitation Services incident report, dated 08/30/2011 at 6:20 p.m., was reviewed on 04/16/2012 at 1:10 p.m. The incident report indicated, " ...[client #5] had a fresh bite mark on his right forearm that had broken the skin...The bite wasn't (sic) witness (sic) by staff but staff are sure that [client #4] did it because of his history of biting...."</p> <p>The facility's reportable incident reports and investigations were reviewed on 04/16/2012 at 1:10 p.m. The record did not indicate an investigation had been initiated to determine the source of client #5's bite mark.</p> <p>During an interview on 04/19/2012 at 2:50 p.m., the Area Director indicated she was unable to locate an investigation of</p>	W0149	<p>Area Director will retrain Program Director on completing investigations thoroughly and within 5 business days.</p> <p>Program Director will complete all BDDS reportable incidents that require an investigation for consumers in the home.</p> <p>Area Director and Quality Assurance Specialist tracks all BDDS reportable incidents by date and all investigations needed for reports.</p> <p>Responsible Party: Area Director, Program Director, Quality Assurance Specialist.</p> <p>Completion Date: 5/20/12</p>	05/20/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G363	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/20/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 84 S WALNUT ST DANVILLE, IN 46122
---	---

(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>the incident. She indicated the incident should have been investigated to determine the source of injury.</p> <p>2. An Indiana Division of Disability and Rehabilitation Services incident report, dated 04/09/2012 at 8:45 a.m., was reviewed on 04/16/2012 at 1:10 p.m. The incident report indicated, "...While getting all the consumers on the van for transport to Day Services, it was noticed by staff that [client #1] had a bite mark on her right forearm...Staff had not witnesses (sic) [client #1] bite herself or bitten by another consumer...."</p> <p>The facility's reportable incident reports and investigations were reviewed on 04/16/2012 at 1:10 p.m. The record did not indicate an investigation had been completed within 5 working days to determine the source of client #1's bite mark.</p> <p>During an interview on 04/19/2012 at 2:50 p.m., the Area Director indicated the facility had initiated, but not completed, the investigation process for determining the source of client #1's bite mark within 5 work days of the incident.</p> <p>An April 2011 policy, titled "Quality and Risk Management" was provided by the Area Director on 04/16/2012 at 3:35 p.m.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G363	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/20/2012
NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 84 S WALNUT ST DANVILLE, IN 46122		
(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 policy indicated, "...Indiana MENTOR promotes a high quality of services and seeks to protect individuals...through oversight of management procedures and company operations, close monitoring of service delivery and through a process of identifying, evaluating and reducing risk to which individuals are exposed...Alleged, suspected, or actual abuse, neglect, or exploitation of an individual...shall be reported to adult protective services...Indiana MENTOR is committed to ensuring the individuals we serve are provided with a safe and quality living environment...Indiana MENTOR is committed to completed a thorough investigation for any event out of the ordinary which jeopardizes the health and safety of any individual served or other employee. Investigation findings will be submitted to the Area Director for review and development of further recommendations as needed within 5 days of the incident...."</p> <p>9-3-2(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G363	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/20/2012
---	--	--	--

NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 84 S WALNUT ST DANVILLE, IN 46122
---	---

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G363		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/20/2012	
NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 84 S WALNUT ST DANVILLE, IN 46122			
(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. Based on record review and interview, the facility failed to thoroughly investigate an allegation of abuse/neglect for 1 of 12 incident reports reviewed for allegations of abuse, neglect and injuries of unknown origin for (client #5).</p> <p>Findings include:</p> <p>An Indiana Division of Disability and Rehabilitation Services incident report, dated 08/30/2011 at 6:20 p.m., was reviewed on 04/16/2012 at 1:10 p.m. The incident report indicated, "...[client #5] had a fresh bite mark on his right forearm that had broken the skin...The bite wasn't (sic) witness (sic) by staff but staff are sure that [client #4] did it because of his history of biting...."</p> <p>The facility's reportable incident reports and investigations were reviewed on 04/16/2012 at 1:10 p.m. The record did not indicate an investigation had been initiated to determine the source of client #5's bite mark.</p> <p>During an interview on 04/19/2012 at 2:50 p.m., the Area Director indicated she was unable to locate an investigation of</p>	W0154	<p>Area Director will retrain Program Director on completing investigations thoroughly and within 5 business days; including allegations of abuse and neglect.</p> <p>Program Director will complete all BDDS reportable incidents that require an investigation for consumers in the home.</p> <p>Area Director and Quality Assurance Specialist tracks all BDDS reportable incidents by date and all investigations needed for reports.</p> <p>Responsible Party: Area Director, Program Director, Quality Assurance Specialist.</p> <p>Completion date: 5/20/12</p>	05/20/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G363	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/20/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 84 S WALNUT ST DANVILLE, IN 46122
---	---

(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 incident. She indicated the incident should have been investigated to determine the source of injury.</p> <p>9-3-2(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G363		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/20/2012	
NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 84 S WALNUT ST DANVILLE, IN 46122			
(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, the facility failed to complete and report the results of an investigation to the Administrator within 5 working days for 1 of 11 of reportable Incident Reports (client #1) investigated by the facility.</p> <p>Findings include:</p> <p>An Indiana Division of Disability and Rehabilitation Services incident report, dated 04/09/2012 at 8:45 a.m., was reviewed on 04/16/2012 at 1:10 p.m. The incident report indicated, "...While getting all the consumers on the van for transport to Day Services, it was noticed by staff that [client #1] had a bite mark on her right forearm...Staff had not witnesses (sic) [client #1] bite herself or bitten by another consumer...."</p> <p>The facility's reportable incident reports and investigations were reviewed on 04/16/2012 at 1:10 p.m. The record did not indicate an investigation had been completed within 5 working days to determine the source of client #1's bite mark.</p>	W0156	<p>Area Director will retrain Program Director on completing investigations thoroughly and within 5 business days; including allegations of abuse and neglect. Program Director will complete all BDDS reportable incidents that require an investigation for consumers in the home. Area Director and Quality Assurance Specialist tracks all BDDS reportable incidents by date and all investigations needed for reports. Responsible Party: Area Director, Program Director, Quality Assurance Specialist. Completion date: 5/20/12</p>	05/20/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G363	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/20/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 84 S WALNUT ST DANVILLE, IN 46122
---	---

(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>During an interview on 04/19/2012 at 2:50 p.m., the Area Director indicated the facility had initiated, but not completed, the investigation process for determining the source of client #1's bite mark within 5 work days of the incident.</p> <p>9-3-2(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G363		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/20/2012	
NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 84 S WALNUT ST DANVILLE, IN 46122			
(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			
W0369	<p>483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, interview and record review, the facility failed to ensure all medications were administered without error for 1 additional client (client #5).</p> <p>Findings include:</p> <p>During observation of medication administration on 04/17/2012 at 6:30 a.m., client #5 received one packet of Nexium (medication for acid reflux) in 3 tablespoons of applesauce along with his other oral medications prescribed for administration at 6:00 a.m.</p> <p>The MAR (Medication Administration Record) was reviewed on 04/17/2012 at 8:30 a.m.</p> <p>The Medication Administration Record (MAR), dated 04/01/2012-04/30/2012, indicated, "...NEXIUM 40 MG (milligram) 1 PACKET DISSOLVED IN 4-8 OUNCES OF WATER DAILY-ADMINISTER ORALLY...."</p> <p>The physician's orders, dated 04/01/2012-04/30/2012, indicated, "...NEXIUM 40 MG (milligram) 1</p>	W0369	<p>Program Director or Home Manager will retrain staff on following physician orders and administering medications; including dissolving medication. Home Manager will complete medication observations 3 times a week for the next 30 days to ensure all medications are administered as prescribed. Ongoing, Home Manager will complete medication observations per established frequency for HM observations. Responsible Party: Home Manager and Program Director Completion Date: 5/20/12</p>	05/20/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G363	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/20/2012
NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 84 S WALNUT ST DANVILLE, IN 46122		
(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>PACKET DISSOLVED IN 4-8 OUNCES OF WATER DAILY-ADMINISTER ORALLY...."</p> <p>During an interview on 04/19/2012 at 3:20 p.m., the Area Director indicated the medication should have been administered according to physician's orders.</p> <p>9-3-6(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G363		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/20/2012	
NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 84 S WALNUT ST DANVILLE, IN 46122			
(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			
W0436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview, the facility failed ensure a client wore his prescription eye glasses and failed to provide a recommended adaptive spoon for use at day services for 2 of 4 sampled clients with adaptive equipment (clients #1 and #4).</p> <p>Findings include:</p> <p>1. During observations on 04/16/2012 between 4:55 p.m. and 6:30 p.m. and on 04/18/2012 between 6:00 a.m. and 8:35 a.m., client #4 did not wear eye glasses.</p> <p>Client #4's record was reviewed on 04/19/2012 at 12:20 p.m.</p> <p>A vision screening, dated 04/05/2012 indicated client #4's prescription for eye glasses was unchanged from the previous exam. The record indicated, " ...rarely wears his glasses...."</p> <p>The Individual Support Plan (ISP), dated 02/16/2012, indicated, "...Results from</p>	W0436	<p>Physician sent order to discontinue the use of eye glasses for client #4 based on repeated attempts to encourage to wear and continually refusals. Home Manager purchased weighted spoons for client #2 and #4 to be given and kept at day services for use during afternoon mealtime. Home Manager and Program Director to complete observations at day services during mealtime once weekly to ensure adaptive equipment is being used per dining plan. Responsible Party: Home Manager and Program Director Completion Date: 5/20/12</p>	05/20/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G363	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/20/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 84 S WALNUT ST DANVILLE, IN 46122
---	---

(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>last vision exam: Extremely nearsighted-glasses. Willingness to wear glasses: Wear as much as he will allow...." The ISP did not include a program plan to encourage client #4 to wear his glasses.</p> <p>During an interview on 04/19/2012 at 3:05 p.m., the Program Director (PD) indicated client #4 has glasses but refused to wear them. She indicated there was not currently a goal to encourage client #4 to wear his glasses.</p> <p>2. During Day Service observations on 04/17/2012 at 10:45 a.m., client #1 had a container of "heat and serve" ravioli, carrots, and a container of orange slices in her lunch box. The lunch box did not contain silverware.</p> <p>Client #1's record was reviewed on 04/17/2012 at 12:04 p.m.</p> <p>A Dining Plan, dated, 11/16/2011, indicated, "...She uses a divided plate, weighted spoon...."</p> <p>During an interview on 04/17/2012 at 10:45 a.m., Day Service Staff (DSS) #1 and #2 indicated client #1 did not bring adaptive silverware to day services. DSS #2 indicated client #1 used plastic silverware when she ate items that</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G363	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/20/2012
NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 84 S WALNUT ST DANVILLE, IN 46122		
(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>required silverware.</p> <p>During an interview on 04/19/2012 at 2:55 p.m., the Program Director indicated client #1's adaptive spoon should have been sent in her lunch box for food items that required silverware.</p> <p>9-3-7(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G363		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/20/2012	
NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 84 S WALNUT ST DANVILLE, IN 46122			
(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, interview, and record review, the facility failed to ensure clients assisted with meal preparation for 4 of 4 sampled clients and 3 additional clients (clients #1, #2, #3, #4, #5, #6, and #7).</p> <p>Findings include:</p> <p>During observations on 04/16/2012 between 4:55 p.m. and 6:30 p.m., Direct Support Professional (DSP) #4 was in the kitchen preparing the evening meal of BBQ pork, baked potatoes, green beans, tossed salad, and milk, tea and coffee. No clients were in the kitchen during the meal preparation. Clients #1, #4, #5, #6 and #7 were in the living room with the television on. Client #1 was seated in her wheel chair. Clients #6 and #7 were seated on sofas. Client #4 stood in front of the television. Client #5 was seated in his wheelchair, looking out the front door. Client #2 walked through the adjacent dining room. None of the aforementioned clients was asked to assist with meal preparation. Client #3 was asked to assist with setting the dining table. She carried a covered bowl to the table. The House Manager carried other</p>	W0488	Home Manager will retrain staff on appropriate consumer interactions and trainings during mealtime preparations. Home Manager will complete mealtime observations 3 times weekly for the next 30days to ensure clients are involved in meal preparation. Ongoing, Home Manager will complete mealtime observations per established frequency for HM observations. Responsible Party: Home Manager Completion date: 5/20/12	05/20/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G363	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/20/2012
NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 84 S WALNUT ST DANVILLE, IN 46122		
(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>food containers to the table.</p> <p>During an interview on 04/17/2012 at 8:40 a.m. DSP #8 stated, "[Client #1] doesn't like to help in the kitchen." She stated, "[Clients #4 and #5] have issues with drooling so they only help with getting cans out of the cabinet." She indicated clients #2, #3, #6, and #7 were able to help stir food. She indicated client #8 didn't arrive home in time to assist with evening meal preparations.</p> <p>During an interview on 04/19/2012 at 3:40 p.m., the Program Director (PD) stated, "Staff are usually pretty good with active treatment in that home." She stated the "evening staff are newer and the morning staff are more experienced." The PD stated, "[DSP #2] (who was also working the 04/16/2012 evening shift) should have known better." She indicated the clients should have been offered training opportunities in meal preparation.</p> <p>9-3-8(a)</p>				