

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G298	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/25/2016
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NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 317 N MAIN ST HAUBSTADT, IN 47639
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W 0000  Bldg. 00	<p>This visit was for the annual fundamental recertification and state licensure survey.</p> <p>Survey dates: April 21, 22 and 25, 2016.</p> <p>Facility Number: 000817 Provider Number: 15G298 AIM Number: 100243700</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 5/10/16.</p>	W 0000		
W 0210  Bldg. 00	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on record review and interview for 1 of 4 sampled clients (#1), the facility failed to ensure a comprehensive functional assessment was completed</p>	W 0210	A Comprehensive Functional Assessment for Client #1 was completed on 1/19/16. It was in the client file at the time of the survey. This was completed by	05/25/2016

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

TITLE

(X6) DATE

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

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	<p>within 30 days of client #1's admission to the facility.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 4/25/16 at 9:50 AM. The Community Residential Facility Surveyor Worksheet dated 4/16, completed by the facility, indicated "[client #1] was admitted to the group home on 1/14/16." During the record review, there was no Comprehensive Functional Assessment completed for client #1.</p> <p>During interview with the facility nurse on 4/25/16 at 11:00 AM, she stated "[client #1] has not had a Comprehensive Functional Assessment (CFA) at all. It looks like the PCP (primary care physician) indicated it wasn't necessary on his annual physical form. I didn't know it was a requirement for new clients to be given a CFA within their first 30 days. I will have have [Name of Primary Care Physician] make a referral to [name of agency] for a PT assessment as well as OT (occupational therapy) and, since he is non verbal, a speech evaluation as well."</p> <p>9-3-4(a)</p>		<p>the QIDP. Upon admission, Client #1 saw his PCP on 1/14/16. At that time his doctor did not recommend any PT/OT or Speech Therapy so no further follow up was completed. On 4/25/16, a referral was obtained by Client #1's PCP for him to receive a PT/OT/ST evaluation. Client #1's appointment is scheduled for 5/19/16 and the team will follow recommendations made once these evaluations are completed. For any future clients, the QIDP will ensure a CFA is completed and all required evaluations are completed per regulations. Responsible Parties: Program Coordinator (HM), Program Director (QIDP), Nurse</p>				

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W 0418  Bldg. 00	<p>483.470(b)(4)(ii) CLIENT BEDROOMS</p> <p>The facility must provide each client with a clean, comfortable mattress.</p> <p>Based on observation and interview for 1 of 4 additional clients (#6), the facility failed to provide the client with a clean, comfortable mattress.</p> <p>Findings include:</p> <p>During morning observation at the group home on 4/25/16 between 6:00 AM and 7:45 AM, client #6's bed was noted to have a large wet and yellow stain in the middle of the mattress cover. There was also a pungent smell of urine upon entering the bedroom belonging to clients #6 and #1.</p> <p>During interview with the RM (residential manager) on 4/25/16 at 7:00 AM, she stated "we don't have a protective waterproof cover for [client #6's] mattress and we should. This cover (pointing to the white cover enclosing client #6's mattress) is for the treatment of bed bugs. All the clients have one on their mattresses."</p>	W 0418	<p>A new mattress was purchased for Client #6 on 4/26/16 and taken to the home. A water proof mattress cover and a zippered bed bug cover have been purchased and placed over Client #6's mattress for his health and safety. Staff in the home were trained on 5/11/16 on Mattress Care and ensuring appropriate, non-damaged covers are on all client's mattresses at all times and to report to management if there are any concerns with the covers. Management staff will complete a mattress/bed checklist one time per week for four weeks and then two times a month for two months and then at least monthly ongoing.</p> <p>Responsible Parties: Program Coordinator (HM), Program Coordinator (QIDP)</p>	05/25/2016	

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	<p>The facility nurse was interviewed upon arriving at the group home on 4/25/16 at 7:15 AM. While observing client #6's mattress, she stated "this is definitely urine. All clients have these bed bug protector mattress covers on their mattresses. [Client #6] should have a plastic waterproof protective cover over his mattress just underneath the bed bug protector. I can't believe how strong the urine smell is in here (the bedroom). We are definitely going to have to get him a new mattress."</p> <p>9-3-7(a)</p>			