

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G763	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/27/2015
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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 114 S CHESTNUT ST HUNTINGBURG, IN 47542
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W 000 Bldg. 00	<p>This visit was for the annual fundamental recertification and state licensure survey.</p> <p>Survey dates: February 23, 24, 25, 26 and 27, 2015.</p> <p>Facility Number: 012289 Provider Number: 15G763 AIM Number: 100249380</p> <p>Surveyor: Glenn David, RN</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed March 12, 2015 by Dotty Walton, QIDP.</p>	W 000		
W 231 Bldg. 00	<p>483.440(c)(4)(iii) INDIVIDUAL PROGRAM PLAN</p> <p>The objectives of the individual program plan must be expressed in behavioral terms that provide measurable indices of performance.</p> <p>Based on record review and interview for 1 of 3 sampled clients (client #3), the facility failed to track data in regards to the client's diagnosis of dementia.</p>	W 231	Staff were trained 3/6/15 in regards to Dementia tracking for Client #3. Dementia tracking was implemented for Client #3 beginning 3/9/2015. Dementia tracking will be recorded on a	03/29/2015

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

TITLE

(X6) DATE

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

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W 240 Bldg. 00	<p>Findings include:</p> <p>During record review for client #3 on 2/25/15 at 10:50 AM, a physician's order dated 2/1/15 - 2/28/15 indicated client #3 takes "Donepezil HCL (Aricept) 10 milligrams (mg) tab - take one tablet by mouth at bedtime for dementia." The physician's orders also indicated client #3 takes "Namenda 10 mg - take one tablet by mouth 2 times a day for memory."</p> <p>The Program Director was interviewed on 2/26/15 at 3:50 PM. She stated "nothing is currently being utilized to track the client's dementia or the effectiveness of her memory medications."</p> <p>9-3-4(a)</p> <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, record review and interview for 1 of 3 sampled clients (client #3), the facility failed to incorporate the utilization of a gait belt into the client's</p>	W 240	<p>daily basis and monitored by the nurse and management staff monthly. Any patterns of behaviors will be reported to Client #3's physicians. TSI will implement this tracking sheet in the future with any other clients that are placed on medications for Dementia or Alzheimer's. No other clients were affected by this deficient practice. Responsible parties: Nurse, Program Director, Home Manager and Direct Support Professionals</p> <p>Program Director was retrained by the Area Director on goal training objectives, monitoring of the goals/ progress on goals and knowing when to revise goal training objectives and/or</p>	03/29/2015

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W 255 Bldg. 00	<p>Individualized Support Plan (ISP).</p> <p>Findings include:</p> <p>During observation at the group home on 2/25/15 between 5:50 AM and 7:15 AM, client #3 was observed ambulating with staff assist while utilizing a gait belt.</p> <p>Client #3's record was reviewed on 2/25/15 at 10:50 AM. The review indicated an Individual Support Plan/ISP dated 2/1/15.</p> <p>The Program Director was interviewed on 2/26/15 at 3:50 PM. She stated that "client #3 was recently prescribed a gait belt for ambulating with staff assist and it has not been incorporated into her ISP. Currently glasses and a walker are indicated on her ISP as adaptive equipment. The gait belt should have been added to her plan."</p> <p>9-3-4(a)</p> <p>483.440(f)(1)(i) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to</p>				<p>Individualized Support Plan (ISP) on 3/6/15. Client #3's Individualized Support Plan was revised on 3/10/2015 to include her gait belt into the plan. Staff were trained on the new ISP on 3/10/2015. No other clients were affected by this deficient practice. Responsible parties: Nurse, Program Director, Home Manager and Direct Support Professionals</p>		

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	<p>situations in which the client has successfully completed an objective or objectives identified in the individual program plan.</p> <p>Based on record review and interview for 2 of 3 sampled clients (clients #2 and #3), the facility failed to review the clients' monthly progress notes and revise the Individualized Support Plan (ISP), as necessary, to revise objectives when the client has successfully satisfied the criteria set forth by the facility.</p> <p>Findings include:</p> <p>1) During record review of client #2 on 2/25/15 at 9:10 AM, his ISP dated 1/1/15 indicated his medication goal, implemented in 3/2014, was to "state the purpose of his medication Zoloft 150 milligrams (mg) with 2 verbal prompts or less 75% of the opportunities per month for 3 consecutive months."</p> <p>A facility form entitled Indiana Mentor Monthly Summary for June 2014 indicated client #2 "met criteria for the Zoloft medication goal at 100%."</p> <p>A facility form entitled Indiana Mentor Monthly Summary for July 2014 indicated client #2 "met criteria for the Zoloft medication goal at 100%."</p> <p>A facility form entitled Indiana Mentor</p>	W 255	<p>Program Director was retrained by the Area Director on goal training objectives, monitoring of the goals/ progress on goals and knowing when to revise goal training objectives and/or Individualized Support Plan (ISP) on 3/6/15. Interdisciplinary Team (IDT) met on 3/10/15 to review and update Client #2 and Client #3's goal training objectives. Staff were trained on the new goals and new Individualized Support Plan on 3/10/2015. The goals were revised, new goal tracking sheets were put in place and the new goals were started on 3/14/2015. Program Director will review the goals on a monthly basis when she does the monthly review. Program Director and Home Manager will review the goals at least quarterly with the rest of the team and make necessary revisions as needed. No other clients were affected by this deficient practice. Responsible parties: Area Director, Program Director, Home Manager and Direct Support Professionals</p>	03/29/2015

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	<p>Monthly Summary for August 2014 indicated client #2 "met criteria for the Zolofit medication goal at 100%."</p> <p>A facility form entitled Indiana Mentor Monthly Summary for September 2014 indicated client #2 "met criteria for the Zolofit medication goal at 100%."</p> <p>A facility form entitled Indiana Mentor Monthly Summary for October 2014 indicated client #2 " met criteria for the Zolofit medication goal at 100%."</p> <p>A facility form entitled Indiana Mentor Monthly Summary for November 2014 indicated client #2 "met criteria for the Zolofit medication goal at 100%."</p> <p>During interview with the Program Director on 2/26/15 at 3:50 PM, she stated that "client #2's medication goal criteria was met at least by Spring of 2014. His plan should have been revised and a different medication goal established."</p> <p>2) During record review for client #3 on 2/25/15 at 10:50 AM, her ISP dated 2/1/15 indicated that her medication goal, implemented in 3/2014, was to "state the purpose of her medication Paxil 40 mg with 2 verbal prompts or less 75% of the opportunities per month for 3 consecutive</p>			

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	<p>months."</p> <p>A facility form entitled Indiana Mentor Monthly Summary for September 2014 indicated client #3 "met criteria for the Paxil medication goal at 100%,"</p> <p>A facility form entitled Indiana Mentor Monthly Summary for October 2014 indicated client #3 "met criteria for the Paxil medication goal at 100%."</p> <p>A facility form entitled Indiana Mentor Monthly Summary for November 2014 indicated client #3 "met criteria for the Paxil medication goal at 100%."</p> <p>A facility form entitled Indiana Mentor Monthly Summary for December 2014 indicated client #3 "met criteria for the Paxil medication goal at 100%."</p> <p>During interview with the Program Director on 2/26/15 at 3:50 PM, she stated that "client #3's medication goal criteria was met at least by Spring of 2014. Her plan should have been revised and a different medication goal established."</p> <p>9-3-4(a)</p>			

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W 325 Bldg. 00	<p>483.460(a)(3)(iii) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician.</p> <p>Based on record review and interview for 1 of 3 sampled clients (client #1), the facility failed to obtain physician ordered labs within the requested time frame designated by the client's doctor.</p> <p>Findings include:</p> <p>1) During client #1's record review on 2/26/2015 at 8:15 AM, a facility form entitled Psychotropic Medication Review contained physician's orders written that indicated "start LiCO3 (Lithium Carbonate) 450 milligrams (mg) BID [twice daily]. Check Lithium level,</p>	W 325	<p>Client #1's lab work was completed on 2/26/15. Lithium was decreased at that time and the doctor eventually discontinued the medication on March 4th, 2015. Area Director trained the Nurse, Program Director and Home Manager 3/9/15 in regards to follow up on routine screenings and lab work requested by the physician. The team created a "Nurse Instructions" form on 3/9/15 for the nurse to track conversations with staff to better assist with follow up and follow through. The nurse trained the staff on the new Nurse Instruction form on 3/9/15 and the form was implemented on 3/9/15. No other</p>	03/29/2015

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W 331 Bldg. 00	<p>Creatinine, and Thyroid Stimulating Hormone after 5 days from starting medication."</p> <p>During interview with the Program Director on 2/26/15 at 3:50 PM, she stated "the labs have not been done. I'm not sure how the labs got missed. We will have them completed immediately."</p> <p>9-3-6(a)</p> <p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review, and interview for 1 of 3 sampled clients (client #1), the facility failed to obtain physician ordered labs within the requested time frame designated by the client's doctor and for 1 of 3 sampled clients (client #3), the facility's nursing services failed to incorporate the use of a gait belts in the client's Individualized Support Plan (ISP).</p> <p>Findings include:</p> <p>1. Please refer to W240 for 1 of 3 sampled clients (#3), for the failure of the</p>	W 331	<p>clients were affected by this deficient practice. Responsible parties: Area Director, Nurse, Program Director, Home Manager and Direct Support Professionals</p> <p>Program Director was retrained by the Area Director on goal training objectives, monitoring of the goals/ progress on goals and knowing when to revise goal training objectives and/or Individualized Support Plan (ISP) on 3/6/15. Client #3's Individualized Support Plan was revised on 3/10/2015 to include her gait belt into the plan. Staff were trained on the new ISP on 3/10/2015. Client #1's lab work was completed on 2/26/15. Lithium was decreased at that time and the doctor eventually discontinued the medication on March 4th, 2015. Area Director trained the Nurse, Program Director and Home Manager</p>	03/29/2015

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W 454 Bldg. 00	<p>facility to ensure the client's use of a gait belt for ambulation was incorporated into her program plan.</p> <p>2. Please refer to W325 for 1 of 3 sampled clients (#1), for the facility's failure to ensure laboratory studies were done according to the physician's orders.</p> <p>9-3-6(a)</p> <p>483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. Based on observation and interview for 1 of 3 additional clients (client #5), the facility failed to implement protocols for the prevention and/or control of infection.</p> <p>Findings include:</p> <p>1) During the medication pass at the group home on 2/25/15 between 5:50 AM and 6:30 AM, staff #3 did not wear gloves while utilizing a lancet to draw blood to check client #5's blood glucose.</p>	W 454	<p>3/9/15 in regards to follow up on routine screenings and lab work requested by the physician. The team created a "Nurse Instructions" form on 3/9/15 for the nurse to track conversations with staff to better assist with follow up and follow through. The nurse trained the staff on the new Nurse Instruction form on 3/9/15 and the form was implemented on 3/9/15. No other clients were affected by this deficient practice. Responsible parties: Area Director, Nurse, Program Director, Home Manager and Direct Support Professionals</p> <p>Nurse retrained the staff 3/9/15 in regards to Universal Precautions. Nurse or management staff will do a weekly medication administration skills checklist with random staff for four weeks to ensure that staff are using universal precautions. Management staff will continue to do informal observations on a monthly basis to ensure staff continue to implement universal precautions at all times. Should staff fail to use universal precautions, management will proceed with further training and corrective action as needed for individual staff. No other clients</p>	03/29/2015

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	<p>Client #5's physician's orders (reviewed 2/25/15 at 6:30 AM) dated 2/1/15 - 2/28 indicated her diagnosis included, but was not limited to, diabetes.</p> <p>During interview with the facility nurse on 2/26/15 at 11:30 AM, she stated "staff takes client #5 blood glucose every morning,, staff should have put gloves on to check her blood glucose...it protects the staff from blood borne diseases."</p> <p>2) During the medication pass at the group home on 2/25/15 between 5:50 AM and 6:30 AM, staff #3 dropped the lancet on the floor and then attempted to utilize the same lancet to stick client #3's finger to secure a sample of blood.</p> <p>Interview took place with staff #3 during the medication pass on 2/25/15 at 6:05 AM. She stated "I should have thrown the lancet that I dropped on the floor into the sharps container and gotten a different one."</p> <p>The facility nurse was interviewed on 2/26/15 at 11:30 AM. She stated "staff should throw any lancets that fall on the floor away in the sharps container and get a new one."</p> <p>9-3-7(a)</p>		<p>were affected by this deficient practice. Responsible parties: Area Director, Nurse, Program Director, Home Manager and Direct Support Professionals</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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