STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	15G763		05/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL SERVICES SUB LLC	114 S CHESTNUT ST HUNTINGBURG, IN 47542

(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
W 0000 Bldg. 00	This visit was for an investigation of complaint #IN00173079. Complaint #IN00173079: Substantiated. Federal/state deficiency related to the allegation is cited at W149. Dates of survey: May 28 and 29, 2015 Facility Number: 0012289 Provider Number: 15G763 AIM Number: 100249380 This deficiency reflects state findings in accordance with 460 IAC 9.	W 0000		
W 0149 Bldg. 00	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 2 of 3 sampled clients (A and B) and 1 additional client (D), the facility failed to implement its written policies that prohibit abuse, neglect, and mistreatment in regard to staff leaving 3 clients	W 0149	A thorough investigation was started immediately upon the incident being reported and the investigation was completed on 5/8/2015. It was determined that the staff had violated policy and procedure and had not followed plans. The staff in question was	06/28/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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: 15G763	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/29/2015
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 114 S CHESTNUT ST HUNTINGBURG, IN 47542	

(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
	unattended while fishing adjacent to a lake. Findings include: Review of the facility's reportables, internal incident reports and/or investigations were completed on 5/28/15 at 2:15 pm. A report to BDDS (Bureau of Developmental Disabilities Services) dated 5/5/15 indicated "staff took 3 clients (A, B, D) to her home on 5/2/15 so they could fish from a small lake located in the back yard. Staff went inside her home and was inside for 30 minutes leaving the clients unattended outside. Staff was immediately suspended on 5/4/15 when the allegation was made and will remain on suspension pending the outcome of the investigation. All staff will be trained that at no time should clients be left alone during an outing." A Termination Notice dated 5/11/15 indicated "[staff #1's] termination effective date: 5/4/15. Reason for Termination: [Agency] is terminating [staff #1's] employment due to leaving three clients unsupervised while on a community outing, where [staff #1] had taken three clients to fish at a lake at her home. __ On 5/4/15, a client reported to a staff		terminated on 5/12/2015. Staff in the home were retrained on 6/19/15 and 6/23/15 on preventing abuse, neglect and exploitation of clients including incident reporting. Staff will receive corrective action for any future incidents if determined staff failed to follow client plans or failed to prevent abuse, neglect or exploitation. Observations will be completed by supervisory staff at least two times per week for four weeks and then weekly for two months to monitor that staff are following client plans and implementing preventative measures. Management staff will complete random observations of staff on a monthly basis thereafter. The Program Director (QIDP) and Area Director will meet weekly for four weeks and then at least monthly ongoing, to review all incidents to ensure corrective actions have been taken and safeguards are in place following incidents in the home. Responsible parties: Direct Support Professionals, Home Manager, Program Director and Area Director	

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 05/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL SERVICES SUB LLC	114 S CHESTNUT ST HUNTINGBURG, IN 47542

(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
	when they went on an outing with [staff #1] on 5/2/15 to go fishing, [staff #1] went inside her home and left him and two other clients alone outside to fish. __An investigation was completed on 5/4/15, 5/5/15 and 5/6/15, and during the investigation a client reported [staff #1] went into her house to get some fishing items and was in there for a really long time and she was in and out of the house while they were there. A second client reported [staff #1] went inside to get more fishing items and was inside her home for 30 - 45 minutes, and while she was inside he observed another client almost fall two times. Another client stated [staff #1] went inside her home for approximately 15 minutes and he was walking too fast and almost fell. [Staff #1] admitted she did take the three clients to her home to go fishing and she went inside her home for approximately 15 minutes to get more fishing items. [Staff #1] also stated the individuals are to be supervised at all times. __Two of the clients have a 'fall protocol', one client's (client B) protocol states 'he is at risk for falling due to his medical history of seizures, patella femoral instability (sudden movement of the kneecap out of alignment which often occurs suddenly and unpredictably), hand tremors, arthritis to right knee with right knee meniscectomy (surgical removal of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G763		05/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL SERVICES SUB LLC	114 S CHESTNUT ST HUNTINGBURG, IN 47542

(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
	part or all of a torn meniscus).' This client uses a four prong cane and has shoe inserts. The other client's (client A) fall protocol states 'staff should prompt him not to rush, take big steps and to stand up straight, has a tendency to lean forward when walking, may require stand by assistance as he is sometimes unsteady on his feet.' The Employee Information Guide outlines 'inefficiency, incompetence, or negligence in the performance of duties will not be permitted', 'any acts of disrespect, abuse, and/or neglect toward individuals we support will not be tolerated' and 'verbal or physical abuse and neglect of any kind will not be tolerated.' The Code of Conduct states, 'employees are committed to providing quality services. Every individual we serve can expect safety and security in home and community. We are all accountable for ensuring a safe and healthy environment for the individuals we serve.' For these policy violations, we are terminating [staff #1's] employment." During interview with client B on 5/28/15 at 2:05 pm, he stated he "went on a fishing trip with [client A and client D] to [staff #1's] house a few weeks ago. There was a lake in the back yard where they were going to do some fishing. [Staff #1] went into her house for about			

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 05/29/2015
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 114 S CHESTNUT ST HUNTINGBURG, IN 47542	

(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
	30 minutes." Staff #2 was interviewed on 5/28/15 at 2:10 pm. She stated "[client D] told me the next day [staff #1] had taken them fishing and had gone into her house." She indicated "[client D] told me [client A] had almost fallen in the lake. I immediately called the Program Director to report it." Interview with client A was completed on 5/28/15 at 2:50 pm. He stated "[staff #1] took me fishing with [clients B and D]. [Staff #1] went into her house to talk to her husband and while [staff #1] was in the house, I almost lost my balance and fell into the lake. I told [staff #2] about it the next day." The Program Director was interviewed on 5/28/15 at 3:10 pm. She stated "when [staff #1] took [client A], [client B] and [client D] fishing, [staff #1] should not have left the clients unattended for any length of time." Review of the Operating Practices - Supervised Group Living Services - Human Rights, dated April 2011, on 5/28/15 at 4:00 PM indicated "Any instances of abuse, neglect, exploitation, or violation of rights (of the clients) will be communicated to the appropriate local			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G763		05/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL SERVICES SUB LLC	114 S CHESTNUT ST HUNTINGBURG, IN 47542

(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
	authorities, the legal representative, the administrator, identified as the Area Director for this purpose. Any time an individual has been the victim of abuse, neglect or exploitation or mistreatment steps will be taken immediately to protect the individual from further abuse, neglect, exploitation, or mistreatment." This Federal Tag relates to complaint #IN00173079. 9-3-2(a)			