

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/13/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401
---	--

(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	<p>This visit was for a Post Certification Revisit (PCR) to the investigation of complaint #IN00191789 completed on 3/2/16.</p> <p>This visit was in conjunction with the full annual recertification and state licensure survey.</p> <p>Complaint #IN00191789: Not corrected.</p> <p>Survey dates: May 9, 10, 11, 12 and 13, 2016</p> <p>Facility number: 000823 Provider number: 15G304 AIM number: 100249090</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 5/18/16.</p>	W 0000		
W 0104  Bldg. 00	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview for 8 of 8 clients living in the group home</p>	W 0104	A procedure to address recurring issues with bed bugs was developed	06/12/2016

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/13/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401
---	--

(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>(#1, #2, #3, #4, #5, #6, #7 and #8), the facility's governing body failed to exercise operating direction over the facility by failing to to develop and implement a policy to address recurring issues with bed bugs at the group home.</p> <p>Findings include:</p> <p>On 5/9/16 at 12:17 PM, a review of the facility's 4/1/16 Plan of Correction indicated the following, "Procedure for addressing recurring issue with bed bugs is being developed and will be trained on with staff and management team by 4/1/2016." There was no documentation of a procedure being developed and staff trained on the procedure. The Area Director (AD) indicated the procedure was the information the facility received from the pest control company. There was no documentation the facility developed and implemented the pest control information into a facility policy and procedure.</p> <p>On 5/11/16 at 12:56 PM, the Area Director (AD) indicated he could not locate the documentation for the procedure and training so he trained the staff on 5/10/16.</p> <p>On 5/11/16 at 12:56 PM, there was no documentation of a policy and procedure</p>		<p>and all staff will be trained to follow the procedures if there is an occurrence of bed bugs in the home.</p> <p>Quarterly pest control inspections will continue to be completed to check the home.</p> <p>Persons responsible: Area Director, Program Director (QIDP), Program Coordinator</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/13/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401
---	--

(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 0149 Bldg. 00	<p>being developed to address recurring issues with bed bugs. This affected clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>This deficiency was cited on 3/2/16. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to complaint #IN00191789.</p> <p>9-3-1(a)</p> <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 3 of 3 incident/investigative reports reviewed affecting clients #1, #2, #3, #4, #5, #6, #7 and #8, the facility neglected to implement its policies and procedures to prevent client to client abuse, submit an incident report to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner and conduct an investigation of a fire at the group home.</p> <p>Findings include:</p> <p>On 5/9/16 at 12:04 PM, a review of the</p>	W 0149	<p>An advanced Physical Intervention Alternatives class which includes the hierarchy of procedures in regards to least restrictive to most restrictive interventions to be used to help staff develop the skills they need to prevent incidents of client to client abuse.</p> <p>Observations will be completed in the home at least times per week for two weeks and then two times per week for two weeks and then at least weekly ongoing when clients are home to ensure staff are implementing plans to prevent incidents of client to client abuse.</p> <p>The Program Director (QIDP) was retrained on completing incidents in</p>	06/12/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/13/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401
---	--

(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>facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 3/22/16 at 7:00 PM, client #5 hit clients #2 and #8. The 3/23/16 BDDS report indicated, in part, "[Program Coordinator - PC] reported that [client #5] became upset at [client #2] because [client #5] gave [client #2] a dollar and then was upset because he said [client #2] stole it, which [client #2] did not. [PC] attempted to verbally redirect [client #5] but [client #5] continued to escalate and then started attempting to hit [client #2] but [PC] had gotten in between the two clients. [Client #5] continued to escalate and grabbed [PC's] hood of her sweatshirt and [PC] was able to get out of his advances and [client #5] was swinging the whole time and made contact with [client #2] on his left cheek... During the time that [client #5's] behavior was escalating [client #8] became verbally upset and was yelling at [client #5]. [Client #5] turned his direction to [client #8] and [PC] got in between the two of them but they were both fighting back. [Client #5] was making contact with [client #8] through [PC's] body and as [client #5] was striking [PC] it was causing her arms and other parts of her body to run in to [client #8's] arm and stomach... [Client #2's]</p>		<p>a timely manner in compliance with regulations and what incidents require investigations and completing timely investigations. The Area Director will review incidents and investigations with the Program Director weekly to ensure completion for any that occurred that week. Persons responsible: Area Director, Program Director (QIDP), Program Coordinator</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/13/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401
---	--

(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>cheek was red but [client #2] stated it did not hurt and that he was fine. [Client #8] complained that he was hurt and laid himself on the ground but there was no visible injury to [client #8]...." The 3/28/16 Investigation Summary indicated in the Conclusion section, "Evidence supports staff did not intervene appropriately. Staff should have immediately evacuated everyone from the room when [client #5] first stated cursing and threatening the other client. Staff will be retrained on how to intervene appropriately for client to client aggression."</p> <p>On 5/9/16 at 12:07 PM, the Area Director (AD) indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The AD indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>2) On 4/14/16 at 7:00 PM (reported to BDDS on 4/18/16), client #6 hit client #4 in the face while on an outing at the park. The 4/21/16 Investigation Summary indicated in staff #3's statement, in part, "...[Client #6] had become upset because he wanted to leave. [Staff #3] stated that he directed the clients that it was time to leave, so they started walking back. [Client #6] started yelling at [client #4] that he was too slow and to walk faster.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/13/2016
NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401		
(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>[Staff #3] redirected [client #6] and stepped in between the two of them. [Staff #3] stated that he was trying to separate the two but [client #6] was able to punch [client #4] in the face before he could get them separated. [Staff #3] stated that he then managed to separate the two and everything was fine. However, someone at the park witnessed [client #6] hit [client #4] and called the police. The police came and talked to both staff members, [client #6] and [client #4]...." The investigation indicated, "Evidence supports staff did not intervene appropriately. One staff should have separated [client #6] immediately from the others. The other staff member should have remained with the others until the situation was diffused. Staff will be retrained on how to intervene appropriately for client to client aggression."</p> <p>On 5/9/16 at 12:07 PM, the AD indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The AD indicated the facility had a policy and procedure prohibiting abuse of the clients. The AD indicated incidents should be reported to BDDS within 24 hours.</p> <p>3) On 4/29/16 at 8:15 PM, client #5 was making a bag of microwave popcorn and</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/13/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401
---	--

(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>when he took it out of the microwave the bag was on fire. Client #5 threw the bag of popcorn in the trash which caused the trash can to catch on fire. Staff #3 got the fire extinguisher and put the fire out. Staff #3 instructed the clients in the home at the time (#1, #2, #3, #4, #5, #7 and #8) to evacuate the home as a precaution due to the fumes from the fire extinguisher. Staff #3 stayed outside with the clients for about 30-45 minutes to allow the fumes to die down and then everyone returned inside the home.</p> <p>There was no documentation the facility conducted an investigation of the incident.</p> <p>On 5/9/16 at 4:28 PM, client #5 indicated he microwaved popcorn and when he took it out of the microwave the bag caught on fire. Client #5 stated it "almost burned my hand off." Client #5 indicated he threw the bag into the trash. Client #5 indicated the alarm sounded. Client #5 indicated staff put out the fire with a fire extinguisher. Client #5 indicated staff took the trash can outside. Client #5 indicated the house did not get smoky.</p> <p>On 5/9/16 at 4:45 PM, the Program Director (PD) indicated she was not sure if the fire department responded to the fire or not. The PD indicated she did not</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/13/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401
---	--

(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>conduct an investigation. The PD indicated she was not sure if an investigation was conducted.</p> <p>On 5/9/16 at 12:07 PM, the Program Coordinator (PC) indicated staff used a fire extinguisher to put out the fire. The PC indicated there was a spot on the wall from the heat. The PC indicated she was not sure if the fire alarm sounded. The PC indicated she was not sure if the fire department went to the home. The PC indicated staff #3 spoke to the fire department but was not sure if it was in person or on the phone. The PC indicated the fire marshal told the staff to clear out of the house for a certain amount of time. The PC indicated client #5 was able to cook on the stove independently and had used the microwave numerous times in the past without incident. The PC indicated she was not sure if an investigation was conducted. The PC indicated following the incident, she retrained the staff and clients.</p> <p>On 5/9/16 at 12:25 PM, the AD indicated there was no investigation of the incident. The AD stated, "it wasn't nothing big." The AD indicated client #5 burned popcorn in the microwave, threw the bag in the trash and the trash caught on fire. The AD indicated the fire was put out by</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/13/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401
---	--

(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>staff #3 using a fire extinguisher. The AD indicated staff spoke to the fire department on the phone. The AD indicated the clients were evacuated. The AD indicated the fire alarm did not sound. On 5/11/16 at 12:57 PM, the AD indicated an investigation was not conducted. The AD stated he "didn't ask her (PD) to do one."</p> <p>On 5/9/16 at 10:02 PM, a review of the the facility's policy and procedures related to abuse and neglect was conducted. The facility's April 2011 Quality and Risk Management policy indicated, "Indiana MENTOR promotes a high quality of service and seeks to protect individuals receiving Indiana MENTOR services 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." The April 2011 Human Rights policy indicated, in part, "The following actions are prohibited by employees of Indiana MENTOR: abuse, neglect, exploitation or mistreatment of an individual including misuse of an individual's funds; or violation of an individual's rights." The policy indicated, in part, "Indiana MENTOR programs maintain a written list of rights, which take into account the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/13/2016	
NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401			
(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 0153 Bldg. 00	<p>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 punishment." The policy indicated, in part, "Indiana MENTOR follows the BDDS Incident Reporting policy as outlined in the Provider Standards. An incident described as follows shall be reported to the BDDS on the incident report form prescribed by the BDDS... An initial report regarding an incident shall be submitted within twenty-four (24) hours of: a) the occurrence of the incident; or b) the reporter becoming aware of or receiving information about an incident..." The policy indicated, in part, "Indiana MENTOR is committed to completing a thorough investigation for any event out of the ordinary which jeopardizes the health and safety of any individual served or other employee..."</p> <p>This deficiency was cited on 3/2/16. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/13/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401
---	--

(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>of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview for 1 of 3 incident reports reviewed affecting clients #4 and #6, the facility failed to submit an incident report of client to client abuse to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>Findings include:</p> <p>On 5/9/16 at 12:04 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 4/14/16 at 7:00 PM (reported to BDDS on 4/18/16), client #6 hit client #4 in the face while on an outing at the park.</p> <p>On 5/9/16 at 12:07 PM, the Area Director indicated the incident should have been reported to BDDS within 24 hours.</p> <p>This deficiency was cited on 3/2/16. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>	W 0153	<p>The Program Director (QIDP) was retrained on completing incidents in a timely manner in compliance with regulations. The Area Director will review incidents with the Program Director weekly to ensure timely completion for any that occurred that week.</p> <p>Persons responsible: Area Director, Program Director (QIDP)</p>	06/12/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/13/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401
---	--

(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 0154  Bldg. 00	<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 1 of 3 investigative reports reviewed affecting clients #1, #2, #3, #4, #5, #7 and #8, the facility failed to conduct an investigation of a fire at the group home.</p> <p>Findings include:</p> <p>On 5/9/16 at 12:04 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 4/29/16 at 8:15 PM, client #5 was making a bag of microwave popcorn and when he took it out of the microwave the bag was on fire. Client #5 threw the bag of popcorn in the trash which caused the trash can to catch on fire. Staff #3 got the fire extinguisher and put the fire out. Staff #3 instructed the clients in the home at the time (#1, #2, #3, #4, #5, #7 and #8) to evacuate the home as a precaution due to the fumes from the fire extinguisher. Staff #3 stayed outside with the clients for about 30-45 minutes to allow the fumes to die down and then everyone returned inside the home.</p> <p>There was no documentation the facility conducted an investigation of the</p>	W 0154	<p>The Program Director (QIDP) was retrained on completing investigations. The Area Director will review incidents and investigations with the Program Director weekly to ensure completion for any that occurred that week.</p> <p>Persons responsible: Area Director, Program Director (QIDP), Program Coordinator</p>	06/12/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/13/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401
---	--

(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>incident.</p> <p>On 5/9/16 at 4:28 PM, client #5 indicated he microwaved popcorn and when he took it out of the microwave the bag caught on fire. Client #5 stated it "almost burned my hand off." Client #5 indicated he threw the bag into the trash. Client #5 indicated the alarm sounded. Client #5 indicated staff put out the fire with a fire extinguisher. Client #5 indicated staff took the trash can outside. Client #5 indicated the house did not get smoky.</p> <p>On 5/9/16 at 4:45 PM, the Program Director (PD) indicated she was not sure if the fire department responded to the fire or not. The PD indicated she did not conduct an investigation. The PD indicated she was not sure if an investigation was conducted.</p> <p>On 5/9/16 at 12:07 PM, the Program Coordinator (PC) indicated staff used a fire extinguisher to put out the fire. The PC indicated there was a spot on the wall from the heat. The PC indicated she was not sure if the fire alarm sounded. The PC indicated she was not sure if the fire department went to the home. The PC indicated staff #3 spoke to the fire department but was not sure if it was in person or on the phone. The PC indicated the fire marshal told the staff to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/13/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401
---	--

(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>clear out of the house for a certain amount of time. The PC indicated client #5 was able to cook on the stove independently and had used the microwave numerous times in the past without incident. The PC indicated she was not sure if an investigation was conducted. The PC indicated following the incident, she retrained the staff and clients.</p> <p>On 5/9/16 at 12:25 PM, the AD indicated there was no investigation of the incident. The AD stated, "it wasn't nothing big." The AD indicated client #5 burned popcorn in the microwave, threw the bag in the trash and the trash caught on fire. The AD indicated the fire was put out by staff #3 using a fire extinguisher. The AD indicated staff spoke to the fire department on the phone. The AD indicated the clients were evacuated. The AD indicated the fire alarm did not sound. On 5/11/16 at 12:57 PM, the AD indicated an investigation was not conducted. The AD stated he "didn't ask her (PD) to do one."</p> <p>This deficiency was cited on 3/2/16. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>			

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

PRINTED: 07/18/2016

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/13/2016
NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401		
(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	