

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G515	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2015
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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 359 W 47TH ST INDIANAPOLIS, IN 46208
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(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 fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: 6/2/15 and 6/3/15</p> <p>Facility Number: 001029 Provider Number: 15G515 AIMS Number: 100245200</p> <p>This deficiency reflects a state finding in accordance with 460 IAC 9.</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 1 of 4 sampled clients (#4), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure client #4's personal finances were not in excess of the predetermined amount allowed by Medicaid.</p> <p>Findings include:</p>	W 0104	<p>Area Director will retrain Home Manager and Program Director on client assets and Medicaid allowable thresholds Program Director will review the balances of all consumers in the home to determine if any other consumers are over resources. Program Director will request from client #4 account to be made payable to the Arc trust to bring his account under the allowable resource amount. The Client Finance</p>	07/03/2015

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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	<p>Client #4's financial record was reviewed on 6/3/15 at 7:30 AM. Client #4's facility based internal cluster account ledger from 3/1/15 through 6/1/15 was reviewed. Client #4's account ledger indicated a daily average balance of \$6,051.29 from 3/1/15 to 4/1/15, of \$6,466.70 from 4/1/15 through 5/1/15 and of \$7,471.95 from 5/1/15 through 6/1/15.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 6/3/15 at 11:48 AM. QIDP #1 indicated client #4 was in the process of obtaining a trust fund. QIDP #1 indicated client #4's money would be transferred from his account to his trust fund when it was set up. QIDP #1 indicated client #4's personal financial resources exceeded the \$2,000.00 Medicaid limit for an individual receiving services.</p> <p>9-3-1(a)</p>		<p>Specialist will email a monthly report of all clients that identifies the running balance and whether they are over resources. Responsible party: Area Director, Program Director, Home Manager and Client Finance Specialist.</p>		