

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G401	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/01/2016
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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1603 S LYNHURST DR INDIANAPOLIS, IN 46241
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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 the investigation of complaint #IN00186327.</p> <p>Complaint #IN00186327 - Substantiated. Federal/State deficiency related to the allegation(s) is cited at W154.</p> <p>Dates of Survey: January 28, 29, February 1, 2016</p> <p>Provider Number: 15G401 Aim Number: 100244390 Facility Number: 000915</p> <p>This deficiency also reflects state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 2/5/16.</p>	W 0000		
W 0154 Bldg. 00	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview, the facility failed to thoroughly investigate 1 of 2 incidents/investigations reviewed for allegations of abuse (client #1).</p>	W 0154	The Program Director and Quality Assurance Specialist will receive retraining on investigations including reporting to the administrator or designee the results within 5 work days and	03/02/2016

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>Findings include:</p> <p>The facility's reportable incident reports were reviewed on 1/28/16 at 1:34p.m. A reportable incident report, dated 11/5/15, indicated client B had alleged facility staff (#5 and #6) had mistreated client F. Client B had alleged staff had sat on client F, had taken client F's eyeglasses and had taken food away from client F for a behavior. The investigation indicated client B had a history and programming in place for being dishonest and making up stories on staff and his family members. The investigation included the interview of the clients and the 2 staff involved in the allegation. There was no documentation the other direct care staff who worked at the group home had been interviewed.</p> <p>Professional staff #1 was interviewed on 1/28/16 at 3:02p.m. Staff #1 indicated there were no other documented client interviews for the 11/5/15 investigation. Staff #1 indicated the facility should have interviewed and documented all direct care staff who worked at the group home for the 11/5/15 allegation.</p> <p>This federal tag relates to complaint #IN00186327.</p>		<p>also ensuring that all parties related to the incident are interviewed so that a thorough investigation can be completed.</p> <p>All future incident reports will be reviewed by the Area Director and Regional Quality Assurance Specialist to determine if an investigation needs to be completed. All future investigations will be reviewed for thoroughness by the Area Director and Regional Quality Assurance Specialist. If the investigations are not thorough enough the Regional Quality Assurance Specialist will provide immediate feedback to the Program Director and necessary changes will be made.</p> <p>Responsible Party: Home Manager, Program Director, Regional Quality Assurance Specialist, Area Director.</p>				

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

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FORM APPROVED

OMB NO. 0938-0391

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	9-3-2(a)				