

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G394	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  03/06/2015
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NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 701 RILEY BLVD BEDFORD, IN 47421
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W 000  Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Survey Dates: March 3, 4, 5 and 6, 2015</p> <p>Facility Number: 000908 Provider Number: 15G394 AIM Number: 100244380</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 3/13/15 by Ruth Shackelford, QIDP.</p>	W 000		
W 262  Bldg. 00	<p>483.440(f)(3)(i) PROGRAM MONITORING &amp; CHANGE</p> <p>The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.</p> <p>Based on record review and interview for 3 of 4 clients in the sample (#5, #6 and #8), the facility's specially constituted committee (HRC - Human Rights Committee) failed to review, approve and</p>	W 262	The Program Director was retrained on process of getting Human Rights Committee approvals for medications used to control behaviors and Behavior Support Plans prior to implementation in the	04/05/2015

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>monitor the implementation of the clients' programs designed to manage inappropriate behavior.</p> <p>Findings include:</p> <p>On 3/4/15 at 11:41 AM a review of client #5's record was conducted. Client #5's 6/3/14 Behavior Support Plan (BSP) indicated he was prescribed Lexapro for behavior control. There was no documentation in client #5's record indicating the HRC reviewed, approved and monitored the implementation of client #5's restrictive BSP.</p> <p>On 3/4/15 at 12:08 PM a review of client #6's record was conducted. Client #6's 12/30/14 BSP indicated he was prescribed Clonidine (attention deficit hyperactivity disorder), Concerta (attention deficit hyperactivity disorder) and Risperdal (threatening/disruptive behavior) as psychotropic medications. There was no documentation in client #6's record indicating the HRC reviewed, approved and monitored the implementation of client #6's restrictive BSP.</p> <p>On 3/4/15 at 12:32 PM a review of client #8's record was conducted. Client #8's 6/3/14 BSP indicated he was prescribed Carbamazepine and Venlafaxine as</p>		<p>home, on 3/20/15.</p> <p>The Program Director will continue to monitor the HRC process for all clients on an ongoing basis. The Program Director and Area Director will meet weekly to review request for HRC and approvals of HRC to ensure approval is given prior to training and implementation in the home.</p> <p>Responsible Party: Program Director, Area Director</p>	

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W 263 Bldg. 00	<p>psychotropic medications. There was no documentation in client #8's record indicating the HRC reviewed, approved and monitored the implementation of client #8's restrictive BSP.</p> <p>On 3/4/15 at 12:57 PM, the Quality Assurance Specialist (QAS) indicated she was unable to locate documentation the facility's HRC reviewed, approved and monitored the clients' BSPs. The QAS indicated the HRC should review and approve the clients' BSPs at least annually and when there were revisions to the plans.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(ii) PROGRAM MONITORING &amp; CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on record review and interview for 1 of 4 clients in the sample (#5), the facility's specially constituted committee failed to ensure written informed consent was obtained from client #5 for the implementation of his restrictive behavior plan.</p> <p>Findings include:</p>	W 263	<p>The Program Director was retrained on process of getting clients and guardians approvals prior to HRC approval, on 3/20/15 The Program Director will continue to monitor the HRC process for all clients on an ongoing basis. HRC committee will ensure that clients and/or guardians have been notified prior to signing off on HRC</p>	04/05/2015

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W 312 Bldg. 00	<p>On 3/4/15 at 11:41 AM a review of client #5's record was conducted. Client #5's 6/12/14 Individual Support Plan indicated client #5 was emancipated. Client #5's 6/3/14 Behavior Support Plan (BSP) indicated he was prescribed Lexapro for behavior control. There was no documentation the facility obtained written informed consent from client #5 for the implementation of his restrictive behavior plan.</p> <p>On 3/4/15 at 12:55 PM the Home Manager indicated the facility did not have written informed consent for the implementation of client #5's 6/3/14 BSP.</p> <p>9-3-4(a)</p> <p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for 4 of 4 clients in the sample (#3, #5, #6 and #8), the facility failed to ensure the clients' medication reduction plans were attainable.</p>	W 312	<p>approvals. Program Director and Area Director will meet weekly to review request for HRC and approvals of HRC. Responsible Party: Program Director, Area Director</p> <p>Medication reduction plans will be reviewed and implemented for all clients who have behavior support plans by 4/5/15, based on behavior data to ensure they contain criteria that makes them attainable. The Program Director</p>	04/05/2015

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	<p>Findings include:</p> <p>1) On 3/4/15 at 11:18 AM a review of client #3's record was conducted. Client #3's 10/30/14 Behavior Support Plan (BSP) indicated client #3 took psychotropic medications (Trileptal, Haldol, Seroquel, Buspar and Luvox) to address obsessive compulsive behavior, self injurious behavior and self-stimulation. The plan indicated Haldol was targeted for reduction when client #3's disruptive behavior, food seeking and self injurious behavior decreased 10% from baseline for 3 months. The plan did not include the baseline data for disruptive behavior, food seeking and self injurious behavior. The plan was not attainable due the facility not establishing a baseline for the behaviors to decrease.</p> <p>On 3/4/15 at 1:10 PM, the Quality Assurance Specialist indicated the plan was not attainable. The QAS indicated there was no starting point since there was no baseline data indicated in the plan. The QAS stated the plan would be "hard to attain" without baseline data.</p> <p>2) On 3/4/15 at 11:41 AM a review of client #5's record was conducted. Client #5's 6/3/14 BSP indicated he was prescribed Lexapro for behavior control.</p>		<p>and Area Director will review any updates of behavior support plans that occur, at weekly meetings to ensure compliance. Responsible Party: Program Director, Area Director</p>	

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	<p>The BSP indicated in the Medication Reduction Recommendations section, "If the average daily rate of each of the behaviors listed above (vacating, extreme irritability, self injurious behavior and physical assault) is at or below the specified criterion for the full review period, [name of company] will recommend medication reduction. Such recommendations will be written in the quarterly report and presented at the quarterly meeting." The criterion listed for the behaviors was 0.00.</p> <p>On 3/4/15 at 11:55 AM, the Area Director (AD) stated the plan "did not make any sense." The AD stated the medication reduction plan was "not attainable."</p> <p>3) On 3/4/15 at 12:08 PM a review of client #6's record was conducted. Client #6's 12/30/14 BSP indicated he was prescribed Clonidine (attention deficit hyperactivity disorder), Concerta (attention deficit hyperactivity disorder) and Risperdal (threatening/disruptive behavior) as psychotropic medications. The plan indicated Risperdal was targeted for reduction when client #6's threatening and disruptive behaviors decreased 10% from baseline for 3 consecutive months. The plan did not include the baseline data for threatening</p>			

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	<p>and disruptive behavior. The plan was not attainable due the facility not establishing a baseline for the behaviors to decrease.</p> <p>On 3/4/15 at 1:10 PM, the Quality Assurance Specialist indicated the plan was not attainable. The QAS indicated there was no starting point since there was no baseline data indicated in the plan. The QAS stated the plan would be "hard to attain" without baseline data.</p> <p>4) On 3/4/15 at 12:32 PM a review of client #8's record was conducted. Client #8's 6/3/14 BSP indicated he was prescribed Carbamazepine and Venlafaxine as psychotropic medications for behavior control. The Medication Reduction Plan indicated, in part, "If the average daily rate of each of the behaviors listed above (resistance, destroys property, physical assault and self injurious behavior) is at or below the specified criterion for the full review period, [name of company] will recommend medication reduction. Such recommendations will be written in the quarterly report and presented at the quarterly meeting." The criterion listed for the behaviors was 0.00.</p> <p>On 3/4/15 at 11:55 AM, the Area Director (AD) stated the plan "did not</p>						

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W 331 Bldg. 00	<p>make any sense." The AD stated the medication reduction plan was "not attainable."</p> <p>9-3-5(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 2 of 4 clients in the sample (#3 and #6), the facility's nursing services failed to address the pharmacist's recommendations.</p> <p>Findings include:</p> <p>On 3/4/15 at 11:18 AM a review of client #3's record indicated the Consultant Pharmacist Medication Review form, dated 9/13/14, indicated, "Consider diabetic patients should be on an ACE inhibitor (angiotensin-converting-enzyme used for the treatment of hypertension (elevated blood pressure)) instead of beta blocker." On 11/24/14, the pharmacist documented, "See above. Dx (diagnosis): for Haldol." There was no documentation on the form or in client #3's record indicating the nurse addressed the recommendations. There was no documentation in client #3's monthly</p>	W 331	<p>The Program Nurse and Program Director will be retrained by 3/27/15 on completing documentation addressing pharmacist's recommendations. Supervisory staff will monitor quarterly pharmacist's recommendations to ensure follow up as applicable. Responsible Party: Home Manager, Program Director, Area Director, Nurse</p>	04/05/2015

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	<p>nursing notes or quarterly reviews indicating the nurse addressed the pharmacist's recommendations.</p> <p>On 3/4/15 at 12:08 PM a review of client #6's record indicated the Consultant Pharmacist Medication Review form, dated 9/13/14, indicated, "Need Dx for meds." The pharmacist made the same recommendation on 11/24/14 and 2/28/15. There was no documentation in client #6's monthly nursing notes or quarterly reviews indicating the nurse addressed the pharmacist's recommendations.</p> <p>On 3/4/15 at 1:09 PM, the Quality Assurance Specialist indicated there should be documentation in the clients' records the recommendations were addressed.</p> <p>On 3/5/15 at 12:39 PM, the Licensed Practical Nurse (LPN) indicated she was not sure if she addressed the pharmacist's recommendations for client #3. She indicated if she did she would have documented it in her monthlies. The LPN indicated she reviewed her notes on 3/4/15 and did not find documentation she addressed the recommendations. The LPN indicated she thought she had taken care of client #6's recommendations for obtaining the diagnosis for his</p>			

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W 999 Bldg. 00	<p>medications.</p> <p>9-3-6(a)</p> <p>State Findings:</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met.</p> <p>460 IAC 9-3-6 (b) Health Care Services</p> <p>(b) All personnel who administer medication to residents or observe residents self-administering medication shall have received and successfully completed training using materials approved by the council.</p> <p>This state rule is not met as evidenced by:</p> <p>Based on record review and interview for 3 of 3 employee files (staff #1, #2 and #7) reviewed affecting clients #1, #2, #3, #4, #5, #6, #7 and #8, the facility failed to ensure staff #1, #2 and #7's records included documentation the staff received training in Core A and Core B.</p>	W 999	<p>The Core A and Core B test scores were received from the personnel files the day of this survey exit. The Administrative Assistant and Program Director were retrained on 3/20/15 on obtaining personnel file information timely. TSI will maintain training documentation for staff in personnel files, including Core A and B training documentation and scores in regards to medication administration at all times.</p> <p>Responsible Party: Administrative Assistant, Program Director, Area Director, HR Generalist</p>	04/05/2015

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	<p>Findings include:</p> <p>On 3/4/15 at 11:03 AM, a review of the employee files was conducted. Staff #1, #2 and #7's employee files did not contain documentation the staff received training on the facility's medication administration procedures including Core A and Core B. The training documentation for Core A and B did not include the scores for the tests. This affected clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>On 3/6/15 at 10:37 AM, the Program Director indicated staff #1, #2 and #7 administered medications to the clients. The Program Director indicated the facility should have documentation, including their test scores, the staff successfully completed Core A and B medication training.</p> <p>9-3-6(b)</p>			
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