STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G436	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL SERVICES SUB LLC	11 WASHINGTON ST BROWNSBURG, IN 46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
W0000	This visit was for a recertification and state licensure survey. This visit was in conjunction with a post certification revisit (PCR) to complaint #IN00092140 investigated on 7/11/11. Survey Dates: February 21, 22, 23, 28, 2012 Facility Number: 000950 Aims Number: 100244690 Provider Number: 15G436 Surveyor: Mark Ficklin, Medical Surveyor III These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed on 3/9/12 by Tim Shebel, Medical Surveyor III.	W0000		

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.

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W0125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on observation, interview and record review for 4 of 4 sampled clients (#1, #2, #3, #4), the facility failed to ensure the clients had the right to due process in regard to locked sharp knives. Findings include: An observation was done on 2/21/12 at the group home for clients #1, #2, #3 and #4 from 4:38p.m. to 6:52p.m. At 5:45p.m., direct care staff #3 took a sharp knife from the kitchen and put it in a locked cabinet in the facility's staff office. Staff #3 was interviewed on 2/21/12 at 5:45p.m. Staff #3 indicated the group home kept the sharp knives locked for client safety. Professional staff #1 was interviewed on 2/21/12 at 5:47p.m. Professional staff #1 indicated the sharp knives were kept locked in the facility office due to client #5's behavior and only staff had a key to the locked knives.	W0125	Home Manager has unlocked the knives in the home. Area Director will re-train Program Director on obtaining HRC and Guardian approvals for consumer restrictions. Program Director will determine through IDT if locking knives is warranted for client #5. Program Director will obtain HRC approval for any restrictions implanted in all consumers programming. Area Director will complete an audit of consumer files 1x a month for 3 months to ensure that all consumers have needed HRC approval for any restrictions.	03/29/2012

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	Record review for client #1 was done on 2/23/12 at 12:32p.m. Client #1's 10/24/11 individual support plan (ISP) did not indicate/include the facility practice to lock the sharp knives. Record review for client #2 was done on 2/23/12 at 2:00p.m. Client #2's 2/22/12 ISP did not indicate/include the facility practice to lock sharp knives. Record review for client #3 was done on 2/23/12 at 1:35p.m. Client #3's 1/17/12 ISP did not indicate/include the facility practice to lock sharp knives. Record review for client #4 was done on 2/23/12 at 2:24p.m. Client #4's 4/4/11 ISP did not indicate/include the facility practice to lock sharp knives. Professional staff #1 was interviewed on 2/223/12 at 3:12p.m. Staff #1 indicated the locked knives were due to client #5's behavior. Staff #1 indicated this restriction was not addressed in clients #1, #2, #3 and #4's ISPs. 9-3-2(a)		Responsible Party: Area Director, Program Director Completion Date: 3/29/12	

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W0189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based on record review and interview, the facility failed for 3 identified staff (staff #6, #7, #8) with client incident report medication errors reviewed to ensure staff received retraining on medication administration for 4 of 4 sampled clients (#1, #2, #3, #4.) Findings include: Record review of the facility's incident reports was done on 2/23/12 at 11:10a.m. Incident reports on 12/27/11 (staff #6), 1/15/12 (staff #7) and 2/11/12 (staff #8) indicated staff had made medication errors while administering client medication. There was no documented staff retraining in regards to the administration of client medication for sampled clients #1, #2, #3, and #4. Interview of professional staff #1 was done on 2/23/12 at 3:12p.m. Staff #1 indicated all staff were in need of retraining on the process of administering client medication. Staff #1 indicated they had discussion training with some of the facility staff but there was no documented retraining in place.	W0189	Area Director will retrain Home Manager and Program Director on providing necessary trainings to staff to effectively perform duties surrounding medication administration when errors occur. Area Director will retrain Home Manager of Medication Administration Record documentation review. Program Nurse will retrain staff on medication administration and documentation. Home Manager will complete medication observations 3 times per week for the next 30 days. On-going HM will complete observations per established frequency for HM observations Responsible Party: Area	03/29/2012

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	9-3-3(a)		Director, Program Director, Program Nurse, Home Manager Completion Date: 03/29/12	

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W0249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review, and interview, the facility failed for 2 of 4 sampled clients (#1, #3) to ensure the clients' communication, privacy, leisure and dining training programs were implemented when opportunities were present. Findings include: An observation at the group home was done on 2/21/12 from 4:38p.m. to 6:52p.m. Throughout the observation time, client #3 wore his eyeglasses on his forehead without staff prompts to correctly wear them. Client #1 sat in the living room on the couch (television on) holding a Lego from 4:38p.m. to 5:57p.m. At 5:41p.m., staff #5 asked client #1 to go to the bathroom. Client #1 did not respond and staff #5 went on to assist another client. Staff were not observed to offer client #1 other activity choices during this time frame. At 6:08p.m., staff custodially served client #1 her roast, put salad dressing on her salad and cut up her	W0249	Program Director will retrain staff on proper implementation of training objectives for client #1 and client #3; active treatment at mealtime and ensuring client dignity. Home Manager will complete active treatment observations 3 times per week for the next 30 days to ensure accurate implementation of goals. Home Manager will complete meal time observations 3 times per week for the next 30 days to ensure consumer encouragement to independence level. On-going HM will complete observations per established frequency for HM observations	03/29/2012

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	meat. At 6:42p.m., staff #5 and #6 left client #1 unattended in the bathroom. Client #1 had opened the bathroom door and could be seen from the hallway with her pants down. The record of client #1 was reviewed on 2/23/12 at 12:32p.m. Client #1's 10/24/11 individual support plan (ISP) indicated client #1 had the following training programs: identify wants and needs with 2 words (yes, no), staff should get verbal response to questions; participate in a leisure activity with a peer for 10 minutes; requires reminders to close the bathroom door for privacy; eats independently with some hand over hand to cut up food. The record of client #3 was reviewed on 2/23/12 at 1:35p.m. Client #3's 1/17/12 ISP indicated client #3's had a training program to wear his eyeglasses correctly. The ISP indicated client #3 needed prompts to not wear his eyeglasses on his forehead. Interview of professional staff #1 on 2/23/12 at 3:12p.m. indicated clients #1 and #3's identified training programs should have been implemented at all opportunities. 9-3-4(a)		Area Director will complete random audit once a month for the next 3 months of program files to ensure goal implementation. Responsible Party: Area Director, Program Director, Home Manager. Completion Date: 03/29/2012	

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W0264	483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.			
	Based on observation, record review and interview, the facility's Human Rights Committee (HRC) failed for 8 of 8 clients (#1, #2, #3, #4,#5, #6, #7, #8) to review restrictive intervention: the facility practice of restricting client access to sharp knives. Findings include: An observation was done on 2/21/12 at the group home from 4:38p.m. to 6:52p.m. At 5:45p.m., direct care staff #3 took a sharp knife from the kitchen and put it in a locked cabinet in the facility's staff office. Staff #3 was interviewed on 2/21/12 at 5:45p.m. Staff #3 indicated the group home kept the sharp knives locked for client safety. Professional staff #1 was interviewed on 2/21/12 at 5:47p.m. Professional staff #1 indicated the sharp knives were kept	W0264	Home Manager has unlocked the knives in the home. Area Director will re-train Program Director on obtaining HRC and Guardian approvals for consumer restrictions. Program Director will determine through IDT if locking knives is warranted for client #5. Program Director will obtain HRC approval for any restrictions implanted in all consumers programming. Area Director will complete an audit of consumer files 1x a month for 3 months to ensure that all consumers have needed HRC approval for any restrictions.	03/29/2012

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	locked in the facility office due to client #5's behavior and only staff had a key to the locked knives. Record review of the facility's HRC (Human Rights Committee) reviews from 3/1/11 to 2/23/12 was done on 2/23/12 at 3:00p.m. There was no documentation the HRC had reviewed the facility's restrictive practice of restricting clients (#1, #2, #3, #4, #5, #6, #7, #8) access to sharp knives. Interview of professional staff #1 on 2/23/12 at 3:12p.m. indicated the facility restriction of locked sharp knives had not been presented to and reviewed by the facility's HRC. 9-3-4(a)		Responsible Party: Area Director, Program Director Completion Date: 3/29/12	

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W0436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review and interview, the facility failed for 1 of 4 sampled clients (#4) with adaptive equipment, to provide client #3 with training for the wear of his eyeglasses. Findings include: An observation was done on 2/21/12 from 4:38p.m. to 6:52p.m. at the group home. Client #4 did not wear nor was he prompted to wear eyeglasses during the observation. Record review of client #4 was done on 2/23/12 at 2:24p.m. Client #4's 5/17/10 eye exam indicated client #4 had prescribed eyeglasses. Client #4 had a 4/4/11 individual support plan (ISP). Client #4's ISP did not have documentation of training programs in place to address client #4's refusal to wear prescribed eyeglasses. Interview on 2/23/12 at 3:12p.m. of professional staff #1 indicated client #4	W0436	Area Director will retrain Program Director on the development of goals based on consumer needs and assessments. Program Director will develop a training objective for client # 4 for the refusal of wear eye glasses Home Manager will retrain staff on the implementation of the developed training objective for client #4. Home Manager will complete active treatment observations 3 times per week for the next 30 days to ensure implementation of training goal. Area Director will complete random audit once a month for the next 3 months of program files to ensure goal	03/29/2012

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	had eyeglasses. Staff #1 indicated client #4 often refused to wear his eyeglasses. Staff #1 indicated client #4 did not have a training program in place to address the refusal of wearing them. 9-3-7(a)		implementation. Responsible Party: Area Director, Program Director, Home Manager Completion Date: 3/29/12	