

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G394	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2016
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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 0000 Bldg. 00	<p>This visit was for a full recertification and state licensure survey.</p> <p>Survey Dates: April 19, 20 and 21, 2016</p> <p>Facility Number: 000908 Provider Number: 15G394 AIM Number: 100244380</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 4/26/16.</p>	W 0000		
W 0149 Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>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 5 of 22 incident/investigative reports reviewed affecting clients #2, #6 and #8, the facility neglected to implement its policies and procedures to prevent client to client abuse and conduct a thorough investigation of a medication error resulting in client #8 being hospitalized.</p> <p>Findings include:</p>	W 0149	<p>Staff will be retrained on all clients BSPs and prevention of client to client abuse on 5/6/16. Observations will be completed by supervisory staff at least three times per week for four weeks and then at least two times per week ongoing, to monitor that staff are following client plans and preventing client to client abuse. The Program Director was retrained on completing thorough investigations. All future</p>	05/21/2016

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>On 4/19/16 at 12:10 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 1/28/16 at 8:00 AM, client #8 was lethargic and did not respond in his normal way. Staff called the nurse and the nurse advised the staff to call 911. Client #8 was transported to the hospital and admitted. The 1/29/16 Investigation Summary indicated, in part, in the Factual Findings section, "[Home Manager - HM] was interviewed: When asked what occurred that morning, [HM] said, 'I was heading into work, and staff called me to let me know that [client #8] was lethargic and not responding to staff direction.' [HM] said, when staff told me what was going on, I called the nurse right away, to see what she thought and she told us to call 911, which we did.' [HM] said, 'I got there as the ambulance was pulling away, and I proceeded to follow it to the hospital.' [HM] said, 'I stayed at the hospital the whole day.' [Staff #5], DSP (Direct Support Professional) was interviewed: When asked what occurred that morning, [staff #5] stated, 'I was still observing as a DSP and watched [staff #4] give some of the clients (sic) meds, but didn't see his (sic) give [client #8] his meds.' 'I went into the kitchen with another client and sat</p>		<p>investigations will be reviewed for completeness and thoroughness by the Area Director and Quality Improvement Specialist.</p>	

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	<p>with him while he was eating his breakfast.' When asked what happened after that, [staff #5] said, 'I walked by [client #8] and he was asleep in the LR (living room) chair, which isn't unusual, but I tried to wake him up anyway, because we were leaving soon.' [Staff #5] said, '[Staff #4] called 911 after I had called [HM] and told her what was going on.' [Staff #5] said, 'I went ahead and took 4 clients up to day program and [staff #4] stayed back with [client #8] and the other 3 while waiting for the ambulance.' [Staff #4] was interviewed: When asked what occurred that day while passing meds, [staff #4] said, it was the first day I used the cards and he was used to getting 2 tabs but there was (sic) 2 cards (2 tabs in each bubble) and I gave a dose off of each card.' [Staff #4] added, 'I should have taken more time and double checked the dosage.'" The Conclusion of the investigation indicated, "Evidence supports staff did not follow med administration procedures."</p> <p>The facility failed to ensure a thorough investigation was conducted. The investigation did not indicate the medication client #8 received. The investigation did not clearly indicate client #8 received a double dose of his medication. The investigation did not include a review of client #8's Physician's</p>			

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	<p>Orders. The investigation did not include a timeframe indicating when or how the facility discovered client #8 received a double dose of his medication. The investigation did not include the hospital's discharge instructions or follow up needed. The investigation did not indicate how long client #8 was hospitalized.</p> <p>On 4/20/16 at 11:14 AM, the Program Director (PD) indicated she conducted the investigation. The PD indicated the medication client #8 received a double dose of was Dilantin (seizure control). The PD indicated the investigation should have included the information about the medication he received and a timeframe for when it was discovered he received a double dose of the medication.</p> <p>On 4/20/16 at 11:14 AM, the HM indicated she instructed staff #10 to check client #8's medications when staff #10 went into work at 3:00 PM. The HM indicated she told staff #10 to check client #8's medications after the hospital told her client #8's lab work showed he had barbiturates in his system. The HM indicated she used her phone to look up barbiturates and lab work. The HM indicated she found that Dilantin could show a false positive on lab work for barbiturate use. The HM indicated she</p>			

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	<p>then instructed staff #10 to check client #8's medications. Staff #10 found that client #8 received a double dose of Dilantin. The HM indicated she told the nurse at the hospital the information. The nurse called the physician. The HM indicated client #8 was hospitalized for one night for observation. The HM indicated client #8 had two bubble packs of Dilantin in his medication box and staff #4 popped two pills out of each bubble pack. The HM indicated there should have only been one card in client #8's medication box.</p> <p>On 4/21/16 at 10:26 AM, a focused review of client #8's 3/22/16 Physician's Orders was conducted. On 9/18/15, client #8 was prescribed Dilantin 50 milligrams, two tabs by mouth three times daily for seizure control.</p> <p>On 4/19/16 at 12:19 PM, the Area Director (AD) indicated the investigation should have indicated the medication client #8 received a double dose of. The AD indicated the information was not in the investigation. The AD indicated the investigation did not include the discharge summary from the hospital or how long he was in the hospital. The AD indicated the investigation was not thorough.</p>			

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	<p>On 4/20/16 at 7:37 AM, staff #4 indicated at the time of the incident, he was training a new staff. Staff #4 indicated the medication packaging had just changed back to the bubble packs. Staff #4 stated, "I didn't check the meds before passing." Staff #4 indicated he popped two Dilantin out of one bubble card and when he came to another Dilantin bubble card, he popped out two more Dilantin. Staff #4 indicated he was given disciplinary action and had to retake Core A and B medication administration training.</p> <p>2) On 12/24/15 at 8:20 AM at the facility-operated day program, client #6 poked a peer in the ribs with his finger. The peer pushed client #6. The clients were separated.</p> <p>3) On 3/15/16 at 11:00 PM, client #6 pushed client #2 down to the floor. Client #2 sustained a bruise on his knee. The 3/17/16 Investigation Summary indicated in the Conclusion section, "Evidence supports staff did not intervene appropriately."</p> <p>4) On 3/16/16 at 5:30 PM, client #6 hit client #8 on the shoulder. Client #8 was not injured. The 3/17/16 Investigation Summary indicated in the Conclusion section, "Evidence supports staff did not</p>			

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	<p>intervene appropriately."</p> <p>5) On 4/17/16 at 5:00 AM, client #8 punched client #2 in the face.</p> <p>On 4/20/16 at 11:06 AM, the Program Director (PD) indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The PD indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>The facility's policy and procedures related to abuse and neglect were reviewed on 4/19/16 at 1:10 PM. 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 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 defined neglect as, "e. Failure to provide appropriate supervision, care or</p>			

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W 0154 Bldg. 00	<p>training; e. Failure to provide appropriate supervision, care or training; f. Failure to provide a safe, clean and sanitary environment; g. Failure to provide food and medical services as needed...."</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 22 incident/investigative reports reviewed affecting client #8, the facility failed to ensure a thorough investigation was conducted.</p> <p>Findings include:</p> <p>On 4/19/16 at 12:10 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 1/28/16 at 8:00 AM, client #8 was lethargic and did not respond in his normal way. Staff called the nurse and the nurse advised the staff to call 911. Client #8 was transported to the hospital and admitted. The 1/29/16 Investigation Summary indicated, in part, in the Factual Findings section, "[Home Manager - HM] was interviewed: When</p>	W 0154	The Program Director was retrained on completing thorough investigations. All future investigations will be reviewed for completeness and thoroughness by the Area Director and Quality Improvement Specialist.	05/21/2016

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	<p>asked what occurred that morning, [HM] said, 'I was heading into work, and staff called me to let me know that [client #8] was lethargic and not responding to staff direction.' [HM] said, when staff told me what was going on, I called the nurse right away, to see what she thought and she told us to call 911, which we did.' [HM] said, 'I got there as the ambulance was pulling away, and I proceeded to follow it to the hospital.' [HM] said, 'I stayed at the hospital the whole day.'</p> <p>[Staff #5], DSP (Direct Support Professional) was interviewed: When asked what occurred that morning, [staff #5] stated, 'I was still observing as a DSP and watched [staff #4] give some of the clients (sic) meds, but didn't see his (sic) give [client #8] his meds.' 'I went into the kitchen with another client and sat with him while he was eating his breakfast.' When asked what happened after that, [staff #5] said, 'I walked by [client #8] and he was asleep in the LR (living room) chair, which isn't unusual, but I tried to wake him up anyway, because we were leaving soon.' [Staff #5] said, '[Staff #4] called 911 after I had called [HM] and told her what was going on.' [Staff #5] said, 'I went ahead and took 4 clients up to day program and [staff #4] stayed back with [client #8] and the other 3 while waiting for the ambulance.' [Staff #4] was interviewed:</p>			

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	<p>When asked what occurred that day while passing meds, [staff #4] said, it was the first day I used the cards and he was used to getting 2 tabs but there was (sic) 2 cards (2 tabs in each bubble) and I gave a dose off of each card.' [Staff #4] added, 'I should have taken more time and double checked the dosage.'" The Conclusion of the investigation indicated, "Evidence supports staff did not follow med administration procedures."</p> <p>The facility failed to ensure a thorough investigation was conducted. The investigation did not indicate the medication client #8 received. The investigation did not clearly indicate client #8 received a double dose of his medication. The investigation did not include a review of client #8's Physician's Orders. The investigation did not include a timeframe indicating when or how the facility discovered client #8 received a double dose of his medication. The investigation did not include the hospital's discharge instructions or follow up needed. The investigation did not indicate how long client #8 was hospitalized.</p> <p>On 4/20/16 at 11:14 AM, the Program Director (PD) indicated she conducted the investigation. The PD indicated the medication client #8 received a double</p>			

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	<p>dose of was Dilantin (seizure control). The PD indicated the investigation should have included the information about the medication he received and a timeframe for when it was discovered he received a double dose of the medication.</p> <p>On 4/20/16 at 11:14 AM, the HM indicated she instructed staff #10 to check client #8's medications when staff #10 went into work at 3:00 PM. The HM indicated she told staff #10 to check client #8's medications after the hospital told her client #8's lab work showed he had barbiturates in his system. The HM indicated she used her phone to look up barbiturates and lab work. The HM indicated she found that Dilantin could show a false positive on lab work for barbiturate use. The HM indicated she then instructed staff #10 to check client #8's medications. Staff #10 found that client #8 received a double dose of Dilantin. The HM indicated she told the nurse at the hospital the information. The nurse called the physician. The HM indicated client #8 was hospitalized for one night for observation. The HM indicated client #8 had two bubble packs of Dilantin in his medication box and staff #4 popped two pills out of each bubble pack. The HM indicated there should have only been one card in client #8's medication box.</p>			

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	<p>On 4/21/16 at 10:26 AM, a focused review of client #8's 3/22/16 Physician's Orders was conducted. On 9/18/15, client #8 was prescribed Dilantin 50 milligrams, two tabs by mouth three times daily for seizure control.</p> <p>On 4/19/16 at 12:19 PM, the Area Director (AD) indicated the investigation should have indicated the medication client #8 received a double dose of. The AD indicated the information was not in the investigation. The AD indicated the investigation did not include the discharge summary from the hospital or how long he was in the hospital. The AD indicated the investigation was not thorough.</p> <p>On 4/20/16 at 7:37 AM, staff #4 indicated at the time of the incident, he was training a new staff. Staff #4 indicated the medication packaging had just changed back to the bubble packs. Staff #4 stated, "I didn't check the meds before passing." Staff #4 indicated he popped two Dilantin out of one bubble card and when he came to another Dilantin bubble card, he popped out two more Dilantin. Staff #4 indicated he was given disciplinary action and had to retake Core A and B medication administration training.</p>			

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W 0369 Bldg. 00	<p>9-3-2(a)</p> <p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review and interview for 1 of 9 medications administered to client #8, the facility failed to ensure staff administered his medication as ordered by the physician.</p> <p>Findings include:</p> <p>On 4/20/16 from 6:19 AM to 7:55 AM, an observation was conducted at the group home. At 6:28 AM, client #8 received his medications from staff #2. During the medication administration to client #8, staff #2 placed his Abilify (antipsychotic) into a medication cup. Staff #2 added a Calcium Antacid tablet into the medication cup. Staff #2 added too many antacid tablets to the cup. Staff #2 used a spoon to remove an antacid tablet. Staff #2 also removed client #8's Abilify from the medication cup. Staff #2 continued to prepare the remainder of client #8's medications. The surveyor asked what medication was removed</p>	W 0369	<p>No medication error occurred during the survey but there was potential for an error. Staff involved received a corrective action for causing a potential medication error for client #8. Staff will be retrained on medication administration procedures to prevent medication errors on 5/6/16 by the nurse. Observations by supervisory staff will be completed at least weekly on an on-going basis to ensure that medications are administered properly according to physicians orders.</p>	05/21/2016

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	<p>from the cup. When staff #2 and the Home Manager, who was also observing the medication pass, looked into the antacid container, the staff discovered the Abilify was in the container.</p> <p>Client #2 received his medications as ordered however neither staff #2 or the Home Manager was aware the Abilify was removed from the medication cup. The surveyor intervened to prevent a medication error.</p> <p>On 4/21/16 at 10:26 AM, a focused review of client #8's 3/22/16 Physician's Orders was conducted. Client #8 had an order for Abilify 10 milligrams one tablet by mouth once daily for depression to be administered at 7:30 AM.</p> <p>On 4/20/16 at 11:05 AM, the Home Manager indicated the surveyor intervened and prevented a medication error during the medication pass to client #8. The Home Manager indicated she or staff #2 should have caught the potential error at the time.</p> <p>9-3-6(a)</p>			