

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G266	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/10/2016
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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 642 BELMONT DRIVE EVANSVILLE, IN 47711
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W 0000 Bldg. 00	<p>This visit was for the investigation of complaints #IN00197904 and #IN00199608.</p> <p>Complaint #IN00197904: Substantiated. Federal/State deficiency related to the allegation was cited at W368.</p> <p>Complaint #IN00199608: Substantiated. Federal/State deficiencies related to the allegation were cited at W102, W104, W122, and W149.</p> <p>Dates of Survey: May 5, 6, 9 and 10, 2016.</p> <p>Provider Number: 15G266 AIMS Number: 100248990 Facility Number: 000786</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 5/18/16.</p>	W 0000		

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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W 0102 Bldg. 00	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on observation, interview, and record review for 1 of 3 sampled clients (A), the facility failed to meet the Condition of Participation: Governing Body. The governing body failed to ensure the facility implemented written policies and procedures to prevent neglect and/or abuse of clients in regard to client F's assault upon client A with a butcher knife causing multiple lacerations requiring sutures.</p> <p>Findings include:</p> <ol style="list-style-type: none"> The governing body failed to ensure the facility met the Condition of Participation: Client Protections. The governing body failed to ensure the facility implemented written policy and procedures to prevent neglect and/or abuse of client A in regard to client F's physical aggression. Please see W122. The governing body failed to exercise general policy, budget and operating 	W 0102	<p>Client F was arrested on 5/1/16 and has been in jail since the incident. Client F has been discharged from the group home and will not be returning. Client A was admitted to the hospital for observation on 5/1/16 and discharged on 5/2/16. A client meeting was held on 5/2/16 with all clients to give them an opportunity to discuss how they were feeling about the incident on 5/1/16. Training was done on 5/2/16 with all clients to review "Say No to Abuse" and "Strategies to Cope with Grief". HRC restriction was obtained on 5/2/16 to lock up all sharps for client safety and peace of mind. Individual IDT meetings were held on 5/4/16 for all clients. The behavior specialist met with each client on 5/3/16 to give each of them an opportunity to discuss their feeling about the incident. Each client saw their therapist the week of the incident and they have been seeing their therapist as ordered and deemed necessary by the therapist. IDTs will be held with the client's team</p>	06/09/2016

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W 0104 Bldg. 00	<p>direction over the facility to ensure the facility implemented written policy and procedures to prevent abuse and/or neglect of clients in regard to client F's stabbing of client A with a butcher knife. Please see W104.</p> <p>This federal tag relates to complaint #IN00199608.</p> <p>9-3-1(a)</p> <p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review and interview for 1 of 3 sampled clients (A), the governing body failed to exercise general policy and operating direction over the facility to ensure client F did not physically abuse/assault client A in regard to client F attacking client A with a butcher knife causing multiple stab</p>	W 0104	<p>(including all team members, Behavior Specialist, Nurse, etc.) for changes made to a plan that could affect other housemates (unlocking the knives, removing door alarms, etc.) to ensure all clients feel safe in the home and to limit the restrictions needed. Clients plans will be updated (ISP, RMAP, BSP) as soon as a change is made to the plan by the IDT. All clients were affected by this deficient practice. Responsible parties: Area Director, Program Director, Direct Support Professionals and Human Rights Committee Completion date: 6/9/16</p> <p>Client F was arrested on 5/1/16 and has been in jail since the incident. Client F has been discharged from the group home and will not be returning. Client A was admitted to the hospital for observation on 5/1/16 and discharged on 5/2/16. A client meeting was held on 5/2/16 with all clients to give them an opportunity to discuss how they</p>	06/09/2016

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	<p>wounds.</p> <p>Findings include:</p> <p>The governing body failed to exercise operating direction over the facility to implement written policies and procedures in regard to client F displaying aggressive behaviors (attacking client A with a butcher knife and causing multiple lacerations). Please refer to W149.</p> <p>This federal tag relates to complaint #IN00199608.</p> <p>9-3-1(a)</p>		<p>were feeling about the incident on 5/1/16. Training was done on 5/2/16 with all clients to review "Say No to Abuse" and "Strategies to Cope with Grief". HRC restriction was obtained on 5/2/16 to lock up all sharps for client safety and peace of mind. Individual IDT meetings were held on 5/4/16 for all clients. The behavior specialist met with each client on 5/3/16 to give each of them an opportunity to discuss their feeling about the incident. Each client saw their therapist the week of the incident and they have been seeing their therapist as ordered and deemed necessary by the therapist. IDTs will be held with the client's team (including all team members, Behavior Specialist, Nurse, etc.) for changes made to a plan that could affect other housemates (unlocking the knives, removing door alarms, etc.) to ensure all clients feel safe in the home and to limit the restrictions needed. Clients plans will be updated (ISP, RMAP, BSP) as soon as a change is made to the plan by the IDT. All clients were affected by this deficient practice.</p> <p>Responsible parties: Area Director, Program Director, Direct Support Professionals and Human Rights Committee Completion date: 6/9/16</p>		

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W 0122 Bldg. 00	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, record review and	W 0122	Client F was arrested on 5/1/16	06/09/2016

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	<p>interview, the facility failed to meet the Condition of Participation: Client Protections for 1 of 3 sampled clients (A). The facility neglected to implement its written policy and procedures to prevent abuse in regard to client F's physical aggression and assault with a knife toward client A.</p> <p>Findings include:</p> <p>The facility neglected to implement its written policy and procedures to prevent neglect/abuse in regard to client F assaulting client A with a butcher knife causing him to have to be taken to the Emergency Room for evaluation of numerous bruises, contusions, and lacerations. The facility neglected to implement its written policy and procedures to prevent client to client assault in regard to client F stabbing client A who subsequently received multiple lacerations requiring sutures. Please see W149.</p> <p>This federal tag relates to complaint #IN00199608.</p> <p>9-3-2(a)</p>		<p>and has been in jail since the incident. Client F has been discharged from the group home and will not be returning. Client A was admitted to the hospital for observation on 5/1/16 and discharged on 5/2/16. A client meeting was held on 5/2/16 with all clients to give them an opportunity to discuss how they were feeling about the incident on 5/1/16. Training was done on 5/2/16 with all clients to review "Say No to Abuse" and "Strategies to Cope with Grief". HRC restriction was obtained on 5/2/16 to lock up all sharps for client safety and peace of mind. Individual IDT meetings were held on 5/4/16 for all clients. The behavior specialist met with each client on 5/3/16 to give each of them an opportunity to discuss their feeling about the incident. Each client saw their therapist the week of the incident and they have been seeing their therapist as ordered and deemed necessary by the therapist. IDTs will be held with the client's team (including all team members, Behavior Specialist, Nurse, etc.) for changes made to a plan that could affect other housemates (unlocking the knives, removing door alarms, etc.) to ensure all clients feel safe in the home and to limit the restrictions needed. Clients plans will be updated (ISP, RMAP, BSP) as soon as a change is made to the plan by the IDT. All clients were affected by</p>		

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W 0149 Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview for 1 of 3 sampled clients (A), the facility failed to implement written policies and procedures that prohibit mistreatment, abuse and/or neglect in regard to client F's assault upon client A with a butcher knife causing multiple lacerations requiring sutures.</p> <p>Findings include:</p> <p>The facility's internal reports, BDDS (Bureau of Development Disabilities Services) Reportables and Investigations were reviewed on 5/5/16 at 1:30 PM.</p> <p>A BDDS (Bureau of Developmental Disabilities Services) report dated 5/1/16 indicated "there was an incident at the [Name of Group Home] the evening of 5/1/16 and [client F] physically assaulted [client A]. 911 was called. [Client F] was arrested and remains in jail on a \$10,000 cash bond. [Client A] was transported by</p>	W 0149	<p>this deficient practice. Responsible parties: Area Director, Program Director, Direct Support Professionals and Human Rights Committee Completion date: 6/9/16</p> <p>Client F was arrested on 5/1/16 and has been in jail since the incident. Client F has been discharged from the group home and will not be returning. Client A was admitted to the hospital for observation on 5/1/16 and discharged on 5/2/16. A client meeting was held on 5/2/16 with all clients to give them an opportunity to discuss how they were feeling about the incident on 5/1/16. Training was done on 5/2/16 with all clients to review "Say No to Abuse" and "Strategies to Cope with Grief". HRC restriction was obtained on 5/2/16 to lock up all sharps for client safety and peace of mind. Individual IDT meetings were held on 5/4/16 for all clients. The behavior specialist met with each client on 5/3/16 to give each of them an opportunity to discuss their feeling about the incident. Each client saw their therapist the week of the incident and they have been seeing their therapist as ordered and deemed necessary by the therapist. IDTs</p>	06/09/2016

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	<p>ambulance to [Name of Hospital] where he was treated for scratches and also received stitches. The hospital kept [client A] overnight for observation and he was released from the hospital by noon today. Staff physically intervened in an attempt to get [client F] off of [client A]. [Client B], [client C], [client D] and [client E] were at home during the incident but were not harmed in any way and staff evacuated them from the group home. [Client F] did not attempt to hurt anyone other than [client A]. Plan to Resolve: A client meeting was held first thing this morning 5/2/16 with all 5 clients to give them an opportunity to discuss how they are feeling about last night's incident. We reviewed 'Say No to Abuse' and 'Strategies to Cope with Grief'. Their behavior specialist is planning to meet with each of them the morning of 5/3/16. Each one of them has an appointment this week to meet with their counselor to discuss (the incident)."</p> <p>A Summary of Internal Investigation Report dated 5/5/16 indicated "brief summary of the incident: During an incident on 5/1/16 involving [client F] and [client A], [client F] stabbed [client A] with a knife several times requiring hospitalization of [client A] and [client F] was arrested and taken to jail. [DSP #1] (interviewed on 5/4/16)</p>		<p>will be held with the client's team (including all team members, Behavior Specialist, Nurse, etc.) for changes made to a plan that could affect other housemates (unlocking the knives, removing door alarms, etc.) to ensure all clients feel safe in the home and to limit the restrictions needed. Clients plans will be updated (ISP, RMAP, BSP) as soon as a change is made to the plan by the IDT. All clients were affected by this deficient practice. Responsible parties: Area Director, Program Director, Direct Support Professionals and Human Rights Committee Completion date: 6/9/16</p>	

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	<p>-- [DSP #1] stated that he worked on 5/1/16 at the group home from 8 AM to 8 PM. He stated that he was supposed to work until 6 PM but with the incident, he stayed later. He stated that he worked with [Group home manager] and [DSP #2].</p> <p>-- [DSP #1] stated that the day had gone excellent (sic). He stated that he had taken the clients to the park to play basketball. He stated that it started raining and then it (the weather) cleared up and they played some more. He stated that the clients all had a great time. He stated that they were there about three hours. He stated that he played basketball with [client A], [client F] and [client C] and they all did a great job and had a great time.</p> <p>-- [DSP #1] stated that when they got home, [client F] started helping him fix dinner. He stated that [client F] asked about going back to the park and he told him that it was getting late and they had to eat dinner and take meds but he would take them again next weekend. He stated that [client F] said he was fine with that and there were no problems. He stated that some of the other clients were also assisting with dinner during this time too.</p> <p>-- [DSP #1] stated that about 5 PM, he heard some yells. He stated he didn't know what was going on and he rushed back to the bedrooms and found [client</p>			

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	<p>F] beating up on [client A] in [client F's] bedroom. [DSP #1] stated that he thought [client A] was trying to defend himself when he walked in the bedroom but [client F] was beating up on him. He stated that he didn't see any other clients around at the time. [DSP #1] stated that he tried to verbally redirect [client F] and offered reinforcements and nothing worked to redirect him from [client A]. -- [DSP #1] stated that he was able to redirect [client F] to stop hitting [client A] for a moment and [client A] got away and went toward the living room, but [client F] immediately went after him. He stated that [group home manager] and [DSP #2] told the girls to go to their room and [client B] and [client C] went with them in the med room/office. He stated that he didn't recall seeing [client C] in the living room during the incident. He stated that the incident felt like it went on for hours, but it was only minutes.</p> <p>-- [DSP #1] stated that [client F] followed [client A] in the living room and grabbed the end table and was going to 'try and smash it on [client A]'. [DSP #1] stated that the table probably weighs over 100 lbs (pounds). [DSP #1] stated that he was able to get the table away from [client F] and he didn't hit [client A] with it. He stated that he thought that made [client F] madder and he continued</p>			

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	<p>to try to hit [client A]. He stated that he used the end table to try to keep [client F] away from [client A] and used it as a barrier. He stated that [client A] finally got away from [client F] and left the area and he was checking [client A] to made sure he was ok and [client F] came back with a knife. He stated that it was a big knife. He reported that it was probably 12 - 14 inches long.</p> <p>-- [DSP #1] stated that he didn't know where the knife came from but [client F] started swinging it at [client A] and stabbed him several times. He stated that [client F] kind of poked at [client A] and swung the knife back and forth and kept 'nicking' [client A].</p> <p>He stated that he tried to block [client F] from hitting [client A] with the knife and used the dining room chairs to block [client F]. He stated that [client F] got around the chair and stabbed [client A] in the neck. He stated that this happened in the corner of the living room. He stated that [client F] was trying to 'gouge' [client A] with the knife. He stated that he kept changing the way he held the knife.</p> <p>-- [DSP #1] stated that [client F] was still trying to stab [client A] and he tried to step in and [client F] swung the knife at him and he stepped back and fell over something in the floor and [client F] missed him and he thought that might distract [client F] from [client A] but it</p>			

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	<p>didn't. He stated that [client F] just kept saying 'You're dead! You're dead!' He stated that [client A] was saying he was going to press charges and it seemed to make [client F] madder and he said 'you're gonna press charges?' and [client F] just kept trying to stab at [client A]. [DSP #1] stated that he kept yelling 'where are the police?'</p> <p>-- [DSP #1] stated that [client A] was lying on the floor and there was blood everywhere. He stated that [client A] was beginning to lose consciousness and [client F] raised his arm back to try to stab [client A] again and [DSP #1] believed he was going to stab him in the chest. [DSP #1] stated that when [client F] pulled his arm back over his shoulder, he grabbed [client F's] left wrist that was holding the knife and used both hands to pry the knife from his hand and it fell to the ground and he kicked it out of the way. He stated that when he turned around, [client A] was lying face down on the floor and [client F] was standing over the top of him scratching [client A's] face and head with both hands. [DSP #1] stated that he pushed [client F] off of [client A] and then [client F] grabbed a water bottle or some type of bottle and began hitting [client A] in the temple with it. He stated that he thought [client A] was going to die. He stated that he saw a police officer standing outside the</p>			

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	<p>door and yelled that [client A] had been stabbed and he needed help.</p> <p>-- [DSP #1] stated that the 'cop said something really stupid - that he heard there was a knife and he was waiting for back up.' [DSP #1] stated that he said that he threw the knife outside by him and he needed help and the cop looked down and saw it. He stated that the officer walked in the house and [client F] immediately stopped what he was doing and dropped to his knees and threw his arms up in the air. He stated that [client F] seemed to know exactly what it meant for the cop to be there.</p> <p>-- [DSP #1] stated that he knew that [client F] was going to kill [client A]. He stated that he knew [client F] would not have quit stabbing and hurting [client A] until he was dead and that he yelled that he was going to kill him throughout the incident.</p> <p>-- [DSP#1] stated that after the officer came in the house and handcuffed [client F] and moved him to another area of the room, Fire/Rescue came in and worked on [client A] until the ambulance arrived and they took over working on [client A]. He stated that they then took [client F] to a Sheriff's car. [DSP #1] stated that he wasn't allowed to leave until the police talked to him.</p> <p>Conclusion: There is evidence to support</p>			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G266	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/10/2016
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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 642 BELMONT DRIVE EVANSVILLE, IN 47711
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	<p>client to client abuse by [client F] toward [client A]."</p> <p>The above investigation was dated and electronically signed by the facility's Quality Improvement Specialist.</p> <p>Interview with DSP #1 was completed on 5/9/16 at 9:40 AM. He stated "the assault occurred on Sunday 5/1/16 at approximately 5:00 PM. I had taken the clients to play basketball at the local 4 H club earlier in the day and there were no problems. I heard a scuffle and arguing coming from [client F's] room and went in there and [client F] was beating [client A] with his fists. I tried to break up the fight but couldn't. Then they ended up going to the living room. I tried to get [client F] off of [client A]. At some point, [client F] had picked up a coffee table and was going to hit [client A] over the head with it. I was able to get the table away and after doing so, [client F] had retrieved a knife from the kitchen and began to swing the knife and stabbed [client A] several times. [Client F] cut [client A] in the left forehead, and stabbed him in the left neck and on his left abdominal side underneath his left arm. Through the entire ordeal, [client F] kept saying he was going to kill [client A]. When [client F] raised his arm with the knife above his shoulder, I was able</p>			

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	<p>to grab the knife away from him and threw it out the front door. I noticed there was a policeman in the front yard just standing there and I hollered for help. The policeman had said that he understood someone inside had a knife. I told him that I had thrown the knife out the door and it was in the yard. When he realized the knife was outside, he came into the home. The back up police had also arrived at that time. [Client F] immediately fell to his knees on the floor and put his hands up. The police handcuffed him and took him out of the house. The fire and rescue personnel stabilized [client A] until the paramedics arrived and took over and then took him the the hospital."</p> <p>Client A was interviewed at the facility office on 5/6/16 at 10:00 AM. He stated "I wanted some of [client F's] potato chips and he wouldn't let me have any. They were in a bag in his closet. Even though he told me I couldn't have any I took some anyway. He got mad and started hitting me and wouldn't stop. [DSP #1] tried to break it up as best as he could. I tried to get to the living room but [client F] followed me to the living room and kept hitting me. Then all of a sudden he had a knife and started stabbing me with it. I got cut here (pointing to his left forehead, left side of his neck and</p>			

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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 642 BELMONT DRIVE EVANSVILLE, IN 47711
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	<p>underneath his left arm)." Client A indicated he had received 3 sutures in each of the lacerations to his left forehead, the left side of his neck as well as his left abdomen underneath his left arm. They appeared to be healing well with no signs of infection (drainage, redness, swelling or inflammation).</p> <p>Client F's record review was completed on 5/9/16 at 10:20 AM. Client F's BSP (Behavioral Support Plan) dated 9/6/15 indicated: "Responding to targeted behaviors- Physical assault 1) Direct him to stop the behavior. Remove potential targets from [client F's] vicinity. If she (sic) stops the behavior, go to step 3 below. 2) If the assault continues, physically intervene. Get between [client F] and the target of the assault. Use the agency-approved crisis intervention blocking techniques. If blocking is ineffective, the (sic) least restrictive use agency-approved Physical Intervention Alternatives (PIA) as needed to prevent further aggression. [Client F] may be escorted out of the area when necessary for his/others safety. 3) Stay between [client F] and others and observe him. Implement planned ignoring. 4) When he has been calm for 15</p>			

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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 642 BELMONT DRIVE EVANSVILLE, IN 47711
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	<p>minutes, gradually allow others into the environment. Staff and others may now interact with [client F] if he remains calm.</p> <p>5) If the assault resulted in injury or potentially (but not obviously) could have caused injury, inform the QIDP (Qualified Intellectual Disabilities Professional) or supervisor on-call.</p> <p>6) Using the BPR (behavior problem record), record the incident.</p> <p>If client does not respond to proactive measures or non-restrictive measures use restrictive company approved PIA techniques listed below in the order. Physical restraints should only be used for 10 minute intervals (these should be used ONLY when physical aggression will likely result in harm to herself (sic), others, or when property destruction might affect peoples' health and safety otherwise use blocking/avoidance. Staff may skip less restrictive measures only if health/safety is an imminent threat).</p> <p>a) Escorts</p> <ol style="list-style-type: none"> 1) Side by side escort - walking slightly behind and to the side of the person 2) Hand behind elbow - "L" shaped hand cupping the elbow 3) Hand behind elbow and hand mid back <p>b) Restraints</p>			

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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 642 BELMONT DRIVE EVANSVILLE, IN 47711
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	<p>1) One Arm Hold - Uses "L" shaped hand to restrict one of the client's arms</p> <p>2) Two Arm Hold - same as one arm hold but use 2nd arm to pin clients flailing arm to the side (still only restraining one arm)</p> <p>3) One Arm Hold to the floor - client in a sitting position</p> <p>4) Floor Hold (two person) - use a one arm to the floor restraint, 2nd staff used to restrain legs of client."</p> <p>Interview with the Area Director was completed on 5/5/16 at 3:00 PM. She stated "[client A] went into [client F's] room and asked [client F] if he could have some potato chips. [Client F] said 'no'. The next thing staff heard/saw was [client F] hitting [client A] and potato chips were all over the floor. [DSP #1] went into the room and tried to break up the fight and it somehow escalated and the clients went into the living room. [DSP #1] tried to break it up and [client F] had left (the room) briefly and during that time, [DSP #1] was trying to assist client A who had scratches on his face and neck. Suddenly, [client F] returned from the kitchen area with a long knife and continued to attack [client A] with the knife. [DSP #1] attempted to retrieve the knife from [client F] but wasn't able to do so. [Client A] ended up receiving 3 cuts from the knife - one on his left</p>			

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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 642 BELMONT DRIVE EVANSVILLE, IN 47711
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	<p>forehead, the left side of his neck and underneath his left arm. [DSP #1] was able to finally get the knife away from [client F] and throw it outside. That's when the first policeman arrived and came into the home. At that time, [client F] went to the ground and threw his arms up in the air. By then a second policeman arrived along with an ambulance. [Client F] was arrested and taken to the jail where he remains now on bond and the ambulance took [client A] to the hospital." The AD indicated client F would not be coming back to the group home and they had given his family his belongings.</p> <p>The undated Operating Practices - Supervised Group Living Services was reviewed on 5/9/16 at 4:05 PM and indicated "Any instances of abuse, neglect, exploitation, or violation of rights will be communicated to the appropriate local authorities, the legal representative, the administrator, identified as the Area Director for this purpose, and emergency contact designated by the individual in the ISP (Individual Support Plan). Any time an individual has been the victim of abuse, neglect, or exploitation or mistreatment, steps will be taken immediately to protect the individual from further abuse, neglect, exploitation or mistreatment.</p>			

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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 642 BELMONT DRIVE EVANSVILLE, IN 47711
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	<p>[Name of Facility] programs maintain a written list of rights, which taken into account the requirements of applicable laws, regulations, and purchasing agencies. This list of rights should include, but is not limited to: ensure the clients are not subjected to physical, verbal, sexual, or psychological abuse or punishment."</p> <p>This federal tag relates to complaint #IN00199608.</p> <p>9-3-2(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G266	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/10/2016
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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 642 BELMONT DRIVE EVANSVILLE, IN 47711
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W 0368 Bldg. 00	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 1 of 3 sampled clients (B), the facility failed to assure all drugs are administered in compliance with the physician's order in regards to client B receiving a wrong dose of the medication, Thioridazine (used to treat schizophrenia).</p> <p>Findings include:</p> <p>The facility's internal reports, BDDS (Bureau of Development Disabilities Services) Reportables and Investigations</p>	W 0368	An investigation was completed on 2/9/16 and determined the staff failed to administer medications as ordered. On 3/4/16, all staff were retrained on medication administration, buddy checks and following physicians orders during medication administration. The employee turned in her resignation on 3/22/16 and no longer works for the company. Several staff have been terminated from the home due to excessive medication errors over the past several months and medication errors	06/09/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G266		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/10/2016	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 642 BELMONT DRIVE EVANSVILLE, IN 47711			
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	<p>were reviewed on 5/5/16 at 1:30 PM. A BDDS report dated 2/4/16 indicated "it was reported that [client B] was home from the workshop because he had to do a colon cleansing procedure. It was stated that when he received his noon medication he was given 0.50 mg (milligrams) too much Thioridazine (used to treat schizophrenia). The doctor was contacted and it was decided that since he receives this medication three times a day that staff would take off 0.50 mg at his evening dose. He did not appear to experience any negative side effects. Plan to resolve: The pharmacy was contacted and the medicine at noon will be packaged the same daily from now on so that when [client B] is home from the workshop he will receive his medicine packaged the same way as all his other medications."</p> <p>Client B's record review was completed on 5/9/16 at 11:30 AM. Client B's 5/1 - 5/31/16 physician's orders indicated client B received "Thioridazine 550 mg (milligrams) three times daily for impulse control /physical assault."</p> <p>The facility nurse was interviewed on 5/9/16 at 11:00 AM. She stated "even though [client B] received the wrong dosage at noon, the staff had an opportunity to make up for it with the</p>		<p>have been reduced. Nurse or management staff did random medication observations/ medication administration skills checklist with random staff during the months of March and April at least 2 to 3 times a week for four weeks, then at least 1 to 2 times a week for four weeks to ensure that staff are administering medications correctly. The Nurse or management staff will continue to do informal observations on a monthly basis to ensure staff continue to administer medications correctly. Should staff continue to make medication errors, management will proceed with further training and corrective action as needed for individual staff. No other clients were affected by this deficient practice. Responsible parties: Program Nurse, Program Director, Program Coordinator and Direct Support Professionals Completion date: 6/9/16</p>				

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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 642 BELMONT DRIVE EVANSVILLE, IN 47711
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	<p>evening dosage".</p> <p>This federal tag relates to complaint #IN00197904.</p> <p>9-3-6(a)</p>			