

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
---	--

(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
W0000	<p>This visit was for the post-certification revisit (PCR) survey to the investigation of complaint #IN00117054 completed on 10/26/12.</p> <p>This visit was in conjunction with a PCR survey to the PCR completed on 11/14/12 to the initial survey completed on 8/23/12.</p> <p>This visit was in conjunction with a PCR to the investigation of complaint #IN00119674 completed on 1/7/13.</p> <p>Complaint #IN00117054-Not Corrected.</p> <p>Dates of Survey: 2/19, 2/20 and 2/21/13</p> <p>Facility Number: 012836 AIMS Number: 201091250 Provider Number: 15G809</p> <p>Surveyors: Paula Chika, Medical Surveyor III-Team Leader Claudia Ramirez, Public Health Nurse Surveyor III-RN</p> <p>Quality Review completed 2/28/13 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
---	--

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2013
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280		
(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	
W0104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on interview and record review for 1 of 4 sampled clients (C) and for 4 additional clients (F, G, K and N), the governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent neglect and/or abuse of clients C and F.</p> <p>Based on interview and record review for 1 of 4 sampled clients (C) and for 1 additional client (G), the governing body failed to exercise general policy and operating direction over the facility to develop policy and procedures in regard to transcribing medications, and to develop guidelines for food consistencies/modifications.</p> <p>Findings include:</p>	W0104	<p>Client C 1. Corrective action(s): a. All direct care and dietary staff providing care to client C will be trained in food consistency guidelines, modifications, and food preparations. b. Client-specific diet plans for client C will be reviewed with all direct care, dietary, and SSP staff working with affected client C. c. Client C's medical chart, BSP, SLP recommendations, and dietary assessments will be reviewed for clarifications and physician's orders will be updated. d. Dining plan form created for each diet consistency and reviewed by HSC (DON), RD, TTC, QSP, and MD; form indicates allowed and restricted foods, and minimum criteria for a modified diet. e. Client C's dining plan is available in black daily programming binder for direct care staff to access and refer. f. General Dining and Snack policy updated and implemented, which specifies, "Staff should ensure that all clients receive the correct food consistency per physician's orders. Staff may remove food items from a client if they do not meet the minimum criteria for their recommended consistency (ground meats, thickened liquids, etc.)" g. General Dining and</p>	03/23/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
---	--

(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
			Snack policy updated and implemented, which specifies, "Any/all food items taken out of the dining area must be labeled with the client name, diet order including allergies and/or restrictions, date, and meal. All items leaving the dining area must be covered and/or wrapped." This is to ensure the appropriate food and food consistency is provided for the appropriate client in order to prevent further incidences. h. All staff will be trained on updated General Dining and Snack Policy as well as Family-Style Dining Policy. 2. Prevention for other client(s): a. All other clients with specific physician's orders regarding food modifications will require re-training on food consistencies, modifications, and food preparations; all direct care, dietary, and SSP staff trained in food consistency guidelines, modifications, and food preparations. b. Client-specific diet plans for all clients with food modifications will be reviewed with all direct care, dietary, and SSP staff. c. All clients' medical charts, BSPs, SLP consults (if applicable), and dietary assessments will be reviewed for clarifications regarding diet orders, adaptive equipment, and modified diets; physician's orders will be updated for clarifications. d. Dining plan form created for each diet consistency and reviewed by HSC (DON), RD,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2013
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280		
(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	
			TTC, QSP, and MD; form indicates allowed and restricted foods, and minimum criteria for a modified diet. e. Dining plan per client is available in black programming binder for DSPs to reference under "dietary." f. General Dining and Snack policy updated and implemented, which specifies, "Any/all food items taken out of the dining area must be labeled with the client name, diet order including allergies and/or restrictions, date, and meal. All items leaving the dining area must be covered and/or wrapped." This is to ensure the appropriate food and food consistency is provided for the appropriate client in order to prevent further incidences. g. All staff will be trained on updated General Dining and Snack Policy as well as Family-Style Dining Policy. 3. Measures put in place for prevention: a. All direct care, nursing, dietary, and SSP staff trained in food consistency guidelines, modifications, and food preparations. b. Client-specific diet plans (for all clients) will be reviewed with all direct care, dietary, and SSP staff. c. All clients' medical charts, BSPs, SLP consults (if applicable), and dietary assessments will be reviewed for clarifications regarding diet orders, adaptive equipment, and modified diets; physician's orders will be updated for clarifications. d. Dining plan form created for		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
---	--

(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
			<p>each diet consistency and reviewed by HSC (DON), RD, TTC, QSP, and MD; form indicates allowed and restricted foods, and minimum criteria for a modified diet. e. Dining plan per client is available in black programming binder for DSPs to reference under "dietary." f. General Dining and Snack policy updated and implemented, which specifies "Staff should ensure that all clients receive the correct food consistency per physician's orders. Staff may remove food items from a client if they do not meet the minimum criteria for their recommended consistency (ground meats, thickened liquids, etc.)" g. General Dining and Snack policy updated and implemented, which specifies, "Any/all food items taken out of the dining area must be labeled with the client name, diet order including allergies and/or restrictions, date, and meal. All items leaving the dining area must be covered and/or wrapped." This is to ensure the appropriate food and food consistency is provided for the appropriate client in order to prevent further incidences. h. All staff will be trained on updated General Dining and Snack Policy as well as Family-Style Dining Policy. 4. Corrective actions will be monitored: a. Dining plans will be updated per quarterly review and verified by HSC (DON), RD, TTC, QSP, and MD.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2013
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280		
(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	
			<p>b. Test trays will be conducted by RD bi-monthly to verify accuracy of food consistencies. c. Staff will be trained on client-specific updates and/or changes regarding food consistencies in the future. 5. Date of completion: 03/06/2013 Medication Transcription: - Client F's MAR and MD orders have been reviewed to ensure accuracy on the MAR. - Medication Order Policy was reviewed/revised/implemented to ensure accurate transcriptions of orders onto the MAR. All nurses will be educated on the changes in this policy. - To ensure that all other clients are not affected by this deficiency, the Health Service Coordinator or designee will get all triplet copies of all orders to verify transcriptions of orders to the MAR. - Any inaccuracies found will be immediately corrected according to the above policy. - Responsible Party: Health Services Coordinator to be implemented by 3/23/13 BSPs: - In regards to Clinical Therapy Note dated 02/05/2013 "Client C actively participated in group today... A piece of sugar free candy was used as a reinforcer for client completion of group activities. This reinforcer was also used to make choices." - The facility initiated and</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2013
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280		
(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	
	<p>1. On 02/19/13 at 2:05 PM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was completed and included the following medication error:</p> <p>02/03/13: "During the 9 PM med (medication) pass on 2/3/2013 and 2/4/2012 (sic) [client G] did not receive Topamax 200 mg (milligrams) (for</p>		<p>documented effective corrective action to prevent further incidents. The staff member facilitating that group was re-educated on the dietary needs of client C, (as well as all facility clients) for necessary consistencies and what needs to be avoided to prevent possibility of choking, as clients C is "at higher risk of choking". Date completed: 02/22/2013 - The facilities Registered Dietitian conducted a formal in-service/staff re-training for all clients in regards to necessary food consistency and diet orders. Documentation of staff trained was also obtained. (Date of Training: 03/06/2013) Additionally, - Behavioral Support Services staff have removed any 'reinforcers' that did not meet the criteria noted in the clients dietary orders. This was done for all facility clients. Date completed: 02/27/2013 - Responsible parties: Behavioral Services Coordinator and Behavior Specialists - Date to be fully implemented: 03/07/2013</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2013	
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
(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			
	<p>behaviors) dose due to administration error. He was instead administered a 400 mg dose of Topamax...[Administrator], was notified on 2/8/13 at 1:30 pm. Plan to Resolve: Director of Nursing will review all orders written. There will be education provided on medication transfers and writing orders."</p> <p>An interview was conducted on 02/21/13 at 2:15 PM with the Health Service Coordinator (HSC). The HSC indicated currently there was not a completed nursing policy and procedure book and there was not a policy on how to transcribe new medication orders on the MAR (Medication Administration Record).</p> <p>2. 02/08/13: "[Client C] was asleep during supper and staff brought food back to the unit for her. When she awoke staff retrieved the food from the unit refrigerator. [Client C] sat next to the LDSP (Lead Direct Support Person) (unidentified staff) and began eating. Within a few minutes staff noticed the food was not prepared to the correct consistence (sic). Before they could correct the problem [client C] began choking. Staff performed the Heimlich maneuver and the nurse was contacted to assist with the emergency. After several attempts the food was dislodged and most</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
---	--

(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
	<p>of it was expelled. The nurse left the unit to retrieve a suction pump but [client C] expelled all the material before she returned and the pump was not used. Dr [name] has been notified via phone. New order received and placed for a 'STAT' (emergency/immediate/now) chest x-ray tonight to rule out aspiration as a result of choking. Her vitals are stable and within normal range at this time. Her lungs were clear immediately following episode and oxygen saturation read 99% on room air. No other apparent signs of distress were noted or verbalized. Staff attribute this episode to [client C's] shoveling food and her food not being prepared to the correct consistency. Nursing will be following [client C's] progress over the next several days...Staff will be retrained to more consistently follow [client C's] high risk plan for choking, specifically making sure her food is prepared to the correct consistency. Staff will continue to sit next to [client C] when she eats and remind her to eat slowly and chew her food completely before attempting to swallow."</p> <p>02/15/13: Internal Investigative Report indicated: "Incident date & time: Choking 2/8/12 (sic)...On Friday, 2/8/13, [client C] was sleeping in her room on [name] Hall. Due to this, she missed dinner. [Staff #9], LDSP requested that</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
---	--

(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
--------------------	--	---------------	---	----------------------

	<p>[client C] be prepared a 'to go' tray from the kitchen This meal was prepared and picked up from the kitchen. [Staff #9], LDSP then placed the container with [client C's] meal inside it in the refrigerator on (client C's) [unit]. Around 7:00 pm, [client C] woke up and [staff #10], DSP (Direct Support Person) retrieved her food from the refrigerator. The food was given to [client C], who began eating it. [Staff #9], LDSP then noticed that the food was not prepared to the proper consistency. Additionally, [client C] was eating her food quickly and [staff #9] prompted [client C] to slow down. [Staff #9], LDSP then told [staff #10], DSP that the food was not the proper consistency and that [client C's] bread needs to be soaked in liquid and that this usually occurs in the kitchen before the meal is served to [client C]. As [staff #10] was preparing to soak the bread in liquid, [client C] began choking and was not breathing. [Staff #9] performed the Heimlich maneuver on [client C]. After the first attempt, there was still food hindering [client C's] ability to breath (sic). [Staff #9] told [staff #10] to get the nurse. [Staff #9] then performed the Heimlich maneuver a second time. When [RN (Registered Nurse) #1] arrived, she determined that the suction machine was necessary to remove the food from [client C's] throat.</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
---	--

(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
	<p>She left [unit name] to retrieve the machine. When [RN #1] returned, [client C] had dislodged the remaining food and was breathing fine. [Staff #9], LDSP noted in the Client Injury Report dated 2/8/13 at 7:20 pm that 'client choked due to meal not being prepared properly'. [RN #1] observed [client C] and took her vitals. Additionally, Dr [name], [client C's] Primary Care Physician (PCP) was notified and an emergency chest x-ray was ordered. The x-ray indicated no issues and [client C] was not displaying any signs of distress after that incident." The investigation indicated the Administrator was notified on 02/08/13 at 7:18 PM. The Summary of Evidence indicated: "A go tray was ordered for [client C] on 2/8/13. [Client C] was asleep during dinner time and did not go to the dining room for dinner. [Staff #11] Lead Cook prepared the to go tray, which [staff #12] sat on top of the serving line with no names written on them. [Staff #9], LDSP then picked up the trays and took them back to [unit name]. He wrote [client C's] name on her tray and placed it in the refrigerator on the hall. Later, when [client C] woke from her nap, [staff #10], DSP retrieved the container from the refrigerator and placed it on the table in front of [client C]. [Staff #10], did not open the container and check the contents. She turned away from [client C] to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
---	--

(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
--------------------	--	---------------	---	----------------------

	<p>retrieve a spoon for her. [Staff #9], LDSP was sitting at the table, across from [client C] and was reading a new policy. [Staff #9] did not open the container and check the food to ensure that it was prepared properly. [Client C] opened the tray and began eating. [Staff #9] prompted [client C] to slow down as she was 'shoveling' her food in her mouth. [Staff #9] then told [staff #10] that the milk (sic) had not been soaked in milk. [Staff #10] then went to retrieve a cup of milk to soak [client C's] bread in. It was at this point that she (client C) choked. [Staff #9] performed the Heimlich Maneuver on [client C] twice. [Staff #10] called [RN #1] for assistance. The food was dislodged from [client C's] throat. [RN #1] assessed [client C], contacted [client C's] Physician and got an order for an emergency chest X-ray. The results of the X-ray were normal, as were all of [client C's] vital signs. Recommendations: Corrective Action for [staff #9], LDSP, [staff #12], [staff #11], Lead Cook and [staff #10], DSP for failure to ensure diet consistency was the proper consistency before meal was given to client. Train all involved staff on diet consistencies. Train all Warner staff on diet consistencies. Follow all current and future physician orders. Ensure that clients are properly supervised by staff during meal time. Ensure that clients are</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2013	
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
(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			
	<p>given food prepared to the proper consistency...."</p> <p>Client C's records were reviewed on 02/20/13 at 1:18 PM and contained the following dated documents:</p> <p>11/10/12: Admission Review Form indicated, "[Client C] is scheduled for admission for [name] Hall on Tuesday, November 13, 2012 at 11 am...Special Requirements. It is noted in a risk assessment for Dysphagia (difficulty in swallowing) that [client C] is at 90% risk for choking because she eats too fast & takes bites that are too large. She receives a mechanical (pureed) diet at this time. Prior to this diet order, staff usually fed her due to this risk. Fluids are regular consistency; she uses a sippy cup with a screw-on lid for fluids...."</p> <p>11/13/12: Discharge Instructions from previous placement at time of discharge indicated client C was on a pureed diet.</p> <p>11/13/12: Admission Nursing Assessment indicated client C was on a pureed diet due to eating too fast and too big of pieces.</p> <p>11/13/12: Physician Admission Orders indicated client C was to be on a pureed diet and use a sippy cup with screw on</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2013	
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
(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			
	<p>lid.</p> <p>11/20/12: Comprehensive Nutrition Assessment - Admission Assessment indicated client C's "Diet order" was "1800 kcal (calorie) pureed." "Subjective Information indicated: Client was accompanied by her LDSP for dietary information. [Client C] indicated she liked yogurt and hasn't felt she's had any weight changes. LDSP indicated she has primarily sat with [client C] during meals and states she shovels food whether it is ground or pureed. She has not experienced s/s (signs/symptoms) of choking/aspiration with either food consistency. She brought a sippy cup with her from her previous placement but drinks fine from a regular cup. At meals she is currently receiving ground foods divided into bowls, presented to her one at a time with drinks of liquids in between. Problem Statement 1. Masticatory (muscles used in chewing) difficulty and choking risk related to inability to pace self during meals as evidenced by previous swallow study indicating 90% dysphagia risk due to shoveling of food and observed shoveling behaviors. Nutrition Goals: Goal #1: Tolerate mechanically altered (ground) diet without s/s of choking or aspiration...Goal #4: Pace self during meals and limit shoveling of food in order</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
---	--

(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
	<p>to decrease dysphagia risk.</p> <p>Recommendations 1. d/c (discontinue) 1800 kcal diet restriction, pureed foods, and sippy cup. 2. Change diet to regular (no calories restriction), mechanical soft with moistened ground meats, thin liquids, regular cups, food divided in high-lip bowls or use high-lip divided place. 3. Discourage pureed food at this time as client is observed 'slurping' and shoveling faster with a more liquid food consistency. 4. Provide yogurt cups PRN (as needed) between meals when client is agitated and unable to verbalize hunger. 5. Continue to provide one-on-one monitoring by LDSP at meal time to pace client appropriately and encourage paced feeding. 6. Monitor weights weekly x 4 weeks to assess adequacy of PO (oral) intake. 7. Strongly encourage SLP (Speech-Language) consult to assess dysphagia risk; follow recommendations for diet consistency per SLP recommendations. 8. Obtain occupational therapy consult for adaptive needs/utensils. Summary: [Client C] was observed by RD (Registered Dietitian) her first day in residence at lunch time. She was provided pureed foods per previous orders. Observations included losing 10-25% of food items as they were shoveled into her lap, rapid shoveling of food, and no liquids in between foods. [Client C] was later trialed (sic) on</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2013	
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
(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			
	<p>ground foods divided into high-lip bowls, presented one food item at a time, with drinks of liquid in between food items. While she still shovels, she does not 'slurp' the ground foods as she does the pureed. She has not exhibited s/s of choking and/or aspiration. At this time recommend continuing current therapy with one-on-one assistance at meals, but strongly encourage an SLP consult and swallow study, as this is beyond my scope of practice. [Client C] would benefit from a non-slip mat and possibly other adaptive equipment items. Per her history she does become agitated when she's hungry but will not verbalize hunger. Yogurt cups will be provided and encouraged in between meals PRN...."</p> <p>11/20/12 - 12/01/12: There were no physician orders to indicate client C should be on any diet other than a pureed diet.</p> <p>12/2012: Physician Orders indicated client C was to be on an 1800 Calorie Pureed Diet with Regular Liquids and use a Sippy cup with screw on lid.</p> <p>12/27/12: Nursing Progress Notes at 4 PM indicated, "This writer noted resident was standing in the middle of the floor in the common area. 1 staff member was positioned behind pt (patient) performing</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2013	
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
(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			
	<p>the Heimlich maneuver. Staff stated 'she choked on a sandwich.' Staff attempted several times to dislodge the sandwich (sic). Resident became combative and dropped to the floor on her knees attempting to run away from staff. Staff attempted to dislodge sandwich per Heimlich maneuver. Object was successfully dislodge (sic). Resident cough (sic) several times than (sic) attempted to talk and yell. No s/s of aspiration noted at this time. Dietary notified by this nurse to change diet to pureed with thin liquids per nursing measure. No bread or sandwiches to be given. Called Medical exchange left message for Dr [name] to call facility re[garding] pt. Awaiting call. Res tolerated procedures well. No c/o (complaints of) pain or discomfort. Will continue to monitor."</p> <p>12/27/12: Physician Order indicated, "diet changed to pureed with thin liquids per nursing measure. No bread or sandwiches."</p> <p>12/27/12: Dietary Progress Notes at 1840 hours indicated, "[client C] had an incident tonight and choked on a piece of bread. She was currently being evaluated for appropriateness of a mechanical altered diet. Due to this incident, it is recommended that she receive pureed</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2013	
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
(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			
	<p>foods d/t (due to) continued choking risk until further evaluation by an SLP...RD will continue to follow [client C's] progress and update food consistency per SLP recommendations."</p> <p>12/28/12: Physician Order indicated, "Divided plate, weighted spoon and non-slip mat may be used for dietary purposes. May obtain chest x-ray to R/O aspiration. May obtain SLP consults with swallow study."</p> <p>12/28/12: Nursing Progress Notes at 4:30 PM indicated, "No s/s aspiration noted on x-ray results...."</p> <p>01/2013: Physician Orders indicated client C should be on a Pureed Diet with Regular Liquids and should use a Sippy cup with screw on lid. The Orders indicated the calorie restriction was discontinued on 12/31/12.</p> <p>01/03/13: Physician Order indicated, "Add dx (diagnosis): Dysphagia."</p> <p>01/03/13: Nursing Progress Notes at 2:00 PM indicated, "Received call from [name] at [hospital] re: ST (Speech Therapy) eval[uation]. Schedule appt (appointment) for ST 1-7-13 at 9:30 AM."</p> <p>01/10/13: Medical Visit Summary from</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
---	--

(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
	<p>the Speech-Language Pathologist for the evaluation R/T choking indicated: "[Client C] participated in a clinical swallow evaluation ...Recommend continue thin liquids as tolerated and consider a mechanical soft diet with well-chopped or ground meats, avoid breads and dry solids. If she displays difficulty with soft foods, recommend pureed diet. If signs of aspiration (cough/choke) noted, consider swallow study."</p> <p>01/11/13: Physician Orders indicated, "Discontinue current diet orders. Thin liquids as tolerated. Mechanical Soft Diet (MSD) with well-chopped or ground meats. Avoid breads and dry solids. If difficulty noted with soft food, recommend pureed diet. May crush meds."</p> <p>01/12/13: Hand written note by RD indicated, "Resident's diet consistency has been updated per physician's recommendations. As dry breads/solids are not allowed, broken up breads soaked in milk/broth/gravy will be provided so calories will not be lost. Will continue to follow progress and update per SLP/MD recs (recommendations)." The facility failed to follow the client's physician's order to "Avoid breads" as the order did not indicate breads should be soaked.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2013	
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
(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			
	<p>02/2013: "Physician Orders indicated client C was on Thin Liquids as Tolerated, a Mechanical Soft Diet with Well-Chopped or Ground Meats, Avoid Breads and Dry Solids, If Difficulty noted with soft foods, recommend Pureed Diet, Sippy Cup with screw on lid, Divided Plate, Weighted Spoon, and Non-Slip Mat May be used for Dietary Purposes."</p> <p>02/05/13: Clinical Therapy Note 2 PM - 3 PM indicated: "Client (C) actively participated in group today...A piece of sugar free candy was used as a reinforcer for client completion of group activities. This reinforcer was also used to make choices."</p> <p>02/08/13: Progress Notes 8 AM - 4 PM indicated: "...[client C] ate 100% of lunch in dining room. [Client C] returned to unit. She went to the community kitchen and ate a little taco salad...."</p> <p>02/08/13: Nursing Progress Notes at 7:40 PM indicated: "Dr [name] notified of choking episode. All food particles removed, no respiratory distress noted at this time...Staff report client was shoveling bread and potatoes at a rapid speed...."</p> <p>02/11/13: Physician Order indicated to</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2013
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280		
(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	
	<p>"1. continue MSF (mechanical soft food) diet with thin liquids. 2. No breads/dry cookies/dry foods at meal r/t dysphagia risk. 3. Provide double portion all other foods at meals r/t (related to) weight loss."</p> <p>An interview was conducted on 02/21/13 at 2:15 PM with the Health Service Coordinator (HSC). The HSC indicated client C was at risk for choking. The HSC indicated two separate incidents had occurred which resulted in use of the Heimlich maneuver due to client C's food was not prepared according to the Physician Orders. The HSC indicated prior to 02/20/13 there were no written guidelines in place for the consistency modifications of foods and liquid.</p> <p>3. The facility failed to implement its written policies and procedures to prevent neglect of client C in regard to choking incidents and in regard to an incident of staff to client abuse with client F. The facility neglected to implement its written policy and procedures to ensure facility staff immediately reported an allegation of physical abuse with client F, a choking incident with client C, and to conduct an investigation in regard to injuries of an unknown source for clients K and N. Please see W149.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
---	--

(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
	<p>This federal tag relates to complaint #IN00117054.</p> <p>This deficiency was cited on 10/26/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2013
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280		
(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	
W0149	<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 interview and record review for 1 of 4 sampled clients (C) and for 1 additional client (F), the facility neglected to implement its policy and procedures to prevent neglect of client C in regard to choking incidents and in regard to an incident of staff to client abuse with client F.</p> <p>Findings include:</p>	W0149	<p>Client C 1. Corrective action(s): a. All direct care and dietary staff providing care to client C will be trained in food consistency guidelines, modifications, and food preparations. b. Client-specific diet plans for client C will be reviewed with all direct care, dietary, and SSP staff working with affected client C. c. Client C's medical chart, BSP, SLP recommendations, and dietary assessments will be reviewed for clarifications and physician's orders will be updated. d. Dining plan form created for each diet consistency and reviewed by HSC (DON), RD, TTC, QSP, and MD; form indicates allowed and restricted foods, and minimum criteria for a modified diet. e. Client C's dining plan is available in black daily programming binder for direct care staff to access and refer. f. General Dining and Snack policy updated and implemented, which specifies, "Staff should ensure that all clients receive the correct food consistency per physician's orders. Staff may remove food items from a client if they do not meet the minimum criteria for their recommended consistency (ground meats, thickened liquids, etc.)" g. General Dining and</p>	03/07/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
---	--

(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
			Snack policy updated and implemented, which specifies, "Any/all food items taken out of the dining area must be labeled with the client name, diet order including allergies and/or restrictions, date, and meal. All items leaving the dining area must be covered and/or wrapped." This is to ensure the appropriate food and food consistency is provided for the appropriate client in order to prevent further incidences. h. All staff will be trained on updated General Dining and Snack Policy as well as Family-Style Dining Policy. 2. Prevention for other client(s): a. All other clients with specific physician's orders regarding food modifications will require re-training on food consistencies, modifications, and food preparations; all direct care, dietary, and SSP staff trained in food consistency guidelines, modifications, and food preparations. b. Client-specific diet plans for all clients with food modifications will be reviewed with all direct care, dietary, and SSP staff. c. All clients' medical charts, BSPs, SLP consults (if applicable), and dietary assessments will be reviewed for clarifications regarding diet orders, adaptive equipment, and modified diets; physician's orders will be updated for clarifications. d. Dining plan form created for each diet consistency and reviewed by HSC (DON), RD,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
---	--

(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
			TTC, QSP, and MD; form indicates allowed and restricted foods, and minimum criteria for a modified diet. e. Dining plan per client is available in black programming binder for DSPs to reference under "dietary." f. General Dining and Snack policy updated and implemented, which specifies, "Any/all food items taken out of the dining area must be labeled with the client name, diet order including allergies and/or restrictions, date, and meal. All items leaving the dining area must be covered and/or wrapped." This is to ensure the appropriate food and food consistency is provided for the appropriate client in order to prevent further incidences. g. All staff will be trained on updated General Dining and Snack Policy as well as Family-Style Dining Policy. 3. Measures put in place for prevention: a. All direct care, nursing, dietary, and SSP staff trained in food consistency guidelines, modifications, and food preparations. b. Client-specific diet plans (for all clients) will be reviewed with all direct care, dietary, and SSP staff. c. All clients' medical charts, BSPs, SLP consults (if applicable), and dietary assessments will be reviewed for clarifications regarding diet orders, adaptive equipment, and modified diets; physician's orders will be updated for clarifications. d. Dining plan form created for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
---	--

(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
			<p>each diet consistency and reviewed by HSC (DON), RD, TTC, QSP, and MD; form indicates allowed and restricted foods, and minimum criteria for a modified diet. e. Dining plan per client is available in black programming binder for DSPs to reference under "dietary." f. General Dining and Snack policy updated and implemented, which specifies "Staff should ensure that all clients receive the correct food consistency per physician's orders. Staff may remove food items from a client if they do not meet the minimum criteria for their recommended consistency (ground meats, thickened liquids, etc.)" g. General Dining and Snack policy updated and implemented, which specifies, "Any/all food items taken out of the dining area must be labeled with the client name, diet order including allergies and/or restrictions, date, and meal. All items leaving the dining area must be covered and/or wrapped." This is to ensure the appropriate food and food consistency is provided for the appropriate client in order to prevent further incidences. h. All staff will be trained on updated General Dining and Snack Policy as well as Family-Style Dining Policy. 4. Corrective actions will be monitored: a. Dining plans will be updated per quarterly review and verified by HSC (DON), RD, TTC, QSP, and MD.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
---	--

(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
			<p>b. Test trays will be conducted by RD bi-monthly to verify accuracy of food consistencies. c. Staff will be trained on client-specific updates and/or changes regarding food consistencies in the future. 5. Date of completion: 03/06/2013 BSPs:</p> <ul style="list-style-type: none"> - In regards to Clinical Therapy Note dated 02/05/2013 "Client C actively participated in group today... A piece of sugar free candy was used as a reinforcer for client completion of group activities. This reinforcer was also used to make choices." - The facility initiated and documented effective corrective action to prevent further incidents. The staff member facilitating that group was re-educated on the dietary needs of client C, (as well as all facility clients) for necessary consistencies and what needs to be avoided to prevent possibility of choking, as clients C is "at higher risk of choking". Date completed: 02/22/2013 - The facilities Registered Dietitian conducted a formal in-service/staff re-training for all clients in regards to necessary food consistency and diet orders. Documentation of staff trained was also obtained. (Date of Training: 03/06/2013) Additionally, - Behavioral Support Services staff have removed any 'reinforcers' that did not meet the criteria noted in the clients dietary orders. This was done for all facility clients. Date 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2013
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280		
(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	
	1. On 02/19/13 at 2:05 PM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was completed and included the following incident:		completed: 02/27/2013 - Responsible parties: Behavioral Services Coordinator and Behavior Specialists - Date to be fully implemented: 03/07/2013 Client F: - The staff involved in the alleged incident of abuse/neglect of Client F was suspended on 2/4/13 pending the outcome of an investigation into the incident; - An investigation was completed regarding the abuse/neglect of Client F which substantiated that the staff did not implement proper handle with care techniques as trained; - As a result this staff was terminated on 2/8/13; - Completed by: Transition Team Coordinator/QSP - Date completed by: 2/8/13 For all other clients: - The other staff involved in the incident with Client F were all re-trained after the investigation was completed regarding reporting all incidents of possible abuse/neglect to the administrator immediately.; - Responsible Party: TTC - Date completed by: 2/28/13 with on-going monitoring and re-training staff in the proper reporting of any allegations of abuse, neglect immediately to the administrator		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2013	
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
(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			
	<p>02/02/13: A BDDS report submitted 02/03/13 for an incident on 02/02/13 at 8:28 AM indicated the following regarding client F: "On 2-2-13, [client F], (individual) was eating breakfast in the dining center when he stated that he needed to see the nurse. Staff stated to him that they could transition hi (sic) to the nurse when they were done with breakfast. Staff explained that she had to wait for another staff to get there so that [client F] can be transitioned to the nurse. [Client F] immediately became upset and yelled 'No one cares.' Staff tried to explain to him again that another staff was on the way, but [client F] could not calm down. [Client F] then immediately grabbed staff by her shirt, and began punching her. When staff asked [client F] to stop, he did not. At this point, [client F] was placed in a standing PRT (Physical Restraint Technique)... for 5 minutes. [Client F] calmed down and processed out...Three scratches were noticed on [client F's] face after this incident...[Client F] received First Aid care from the nurse for the scratches...."</p> <p>02/08/13: A BDDS Follow-Up Report indicated: "The investigation into the scratches on [client F's] face revealed that [client F] was agitated and attacked staff member [staff #4]. [Staff #4] failed to control herself and attempted to hit [client</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2013	
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
(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			
	<p>F] for his attack and during the physical altercation used her fingernails to scratch [client F's] face. Additional staff were in the immediate area and intervened, restraining [client F] appropriately. On Monday, February 4, 2013 [WTS] contacted the [name] police department to report abuse of a client...[Staff #4] was suspended on 2-04-13 pending the outcome of our investigation. Her employment with [WTS] was terminated on Friday, February 08, 2013...."</p> <p>02/04/13: Internal Investigation Report indicated the following: "Date of Actual Incident: 2-2-13. Date Investigation Completed: 2-8-13. Dates of the Investigation: 02-04-13 through 02-08-13. Administrator Contacted: [name], 12:00 PM, 2-4-13...Investigation Notes: The investigator interviewed the client and requested employee statements from staff that were present. After reviewing all statements and the video from the cafeteria, it was determined that Staff [staff #4] responded to the client's attack by attempting to strike him and intentionally scratch his face. Other staff in the cafeteria separated [staff #4] from [client F]. [Client F] was checked by the nurse and treated. Conclusion: [Client F] was agitated and attacked [staff #4]. Additional staff were in the immediate area and intervened, restraining [client F]</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2013	
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
(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			
	<p>appropriately. [Staff #4] failed to control herself and attempted to hit [client F] for his attack and during the physical altercation used her fingernails to scratch [client F's] face. Staff separated the two, restrained [client F] and allowed him to calm down. [Staff #4] was walked to the unit by [staff #5] who attempted to help her calm down. It is my recommendation that [staff #4's] employment be terminated immediately. She did not follow her Handle with Care physical training or de-escalation skills during this incident. [Staff #4] blocked the initial attack from [client F] then tried to fight him while [staff #5, #6, #7 and #8] actually did a correct PRT restraint. From the statements I received and interviews I conducted everyone believed [staff #4] 'defended' herself. But they used the words - 'she hit him', which is never appropriate. The incident happened quickly but there were at least two opportunities when [staff #4] could have stepped away. Instead, she attacked [client F] and it looks like she intentionally raked his face with the fingernails of her right hand. According to the police officer and the detective who saw the video and talked to [client F] this is not something they are likely to prosecute so no criminal charges will be filed. I believe due to [staff #4's] striking out at [client F] we are placing her and</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
---	--

(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
--------------------	--	---------------	---	----------------------

	<p>our clients at increased risk by continuing to allow [staff #4] to work with our volatile clients...." Phone interview by investigator with staff #4 indicated, "I asked [staff #4] to tell me what happened in the cafeteria on Saturday morning at breakfast with [client F]. [Client F] was at the door wanting to go to the nurse because he said his jaw hurt. [Client F] is a [unit M] resident and I was working the [unit D] unit. [Staff #5] told [client F] he would have to wait for his staff to take him to the nurse. [Client F] started cussing and threatening me. I had not said anything to him but he was cussing me. [Client F] attacked me, tried to hit me and grabbed my shirt. I hit at his hand trying to get him to let go of my shirt. [Staff #5] tried to restrain [client F] and the [staff #6] was attempting to help but [client F] got loose and came at me again. Once the guys had [client F's] upper body he was still kicking at me. At this point [staff #4] said, 'I'm done. I am done, he attacks me, and I get injured and they suspend me.' She became a bit defensive and said, 'I know the law. He attacked me and I can defend myself.' [Staff #4] mentioned that the police had been to [WTS] and again she said, 'He hit me first and I had to defend myself. He could have killed me.' I told [staff #4] that I had not seen the police... I asked [staff #4] if there was anything else I should know.</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2013	
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
(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			
	<p>She said that the doctor had told her not to move her head and that she was on a muscle relaxer and Motrin and couldn't drive so how was she supposed to get to work. Finally, [staff #4] said that no one had told her about the behaviors of the clients we would have. She said she was told that our clients would be high functioning and would transition out in 3 to 6 months."</p> <p>On 02/21/13 at 4:00 PM staff #4's Timecard was reviewed. The timecard indicated staff #4 clocked in on 02/02/13 at 8:00 AM and clocked out at 11:35 AM. The 2/3/13 BDDS report indicated the incident occurred at 8:28 AM.</p> <p>An interview with the Health Service Coordinator, Transitional Team Coordinator (TTCs) #1 and #2, and Qualified Support Professionals (QSPs) #1 and #2 was conducted on 02/21/13 at 2:00 PM. The QSPs and the TTCs indicated the facility policy on Abuse and Neglect should be followed by all staff. The TTCs indicated the facility had an obligation to protect the clients from injury by staff. The TTCs and QSPs indicated in the incident with client F and staff #4, the facility neglected to follow the policy because staff #4 was not immediately suspended, nor was the incident reported to the administrator</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
---	--

(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
	<p>immediately on 2/2/13 as the incident was reported on 2/4/13.</p> <p>2. 02/08/13: "[Client C] was asleep during supper and staff brought food back to the unit for her. When she awoke staff retrieved the food from the unit refrigerator. [Client C] sat next to the LDSP (Lead Direct Support Person) (unidentified staff) and began eating. Within a few minutes staff noticed the food was not prepared to the correct consistence (sic). Before they could correct the problem [client C] began choking. Staff performed the Heimlich maneuver and the nurse was contacted to assist with the emergency. After several attempts the food was dislodged and most of it was expelled. The nurse left the unit to retrieve a suction pump but [client C] expelled all the material before she returned and the pump was not used. Dr [name] has been notified via phone. New order received and placed for a 'STAT' (emergency/immediate/now) chest x-ray tonight to rule out aspiration as a result of choking. Her vitals are stable and within normal range at this time. Her lungs were clear immediately following episode and oxygen saturation read 99% on room air. No other apparent signs of distress were noted or verbalized. Staff attribute this episode to [client C's] shoveling food and her food not being prepared to the correct</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
---	--

(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
	<p>consistency. Nursing will be following [client C's] progress over the next several days...Staff will be retrained to more consistently follow [client C's] high risk plan for choking, specifically making sure her food is prepared to the correct consistency. Staff will continue to sit next to [client C] when she eats and remind her to eat slowly and chew her food completely before attempting to swallow."</p> <p>02/15/13: Internal Investigative Report indicated: "Incident date & time: Choking 2/8/12 (sic)...On Friday, 2/8/13, [client C] was sleeping in her room on [name] Hall. Due to this, she missed dinner. [Staff #9], LDSP requested that [client C] be prepared a 'to go' tray from the kitchen This meal was prepared and picked up from the kitchen. [Staff #9], LDSP then placed the container with [client C's] meal inside it in the refrigerator on (client C's) [unit]. Around 7:00 pm, [client C] woke up and [staff #10], DSP (Direct Support Person) retrieved her food from the refrigerator. The food was given to [client C], who began eating it. [Staff #9], LDSP then noticed that the food was not prepared to the proper consistency. Additionally, [client C] was eating her food quickly and [staff #9] prompted [client C] to slow down. [Staff #9], LDSP then told [staff</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
---	--

(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
	#10], DSP that the food was not the proper consistency and that [client C's] bread needs to be soaked in liquid and that this usually occurs in the kitchen before the meal is served to [client C]. As [staff #10] was preparing to soak the bread in liquid, [client C] began choking and was not breathing. [Staff #9] performed the Heimlich maneuver on [client C]. After the first attempt, there was still food hindering [client C's] ability to breath (sic). [Staff #9] told [staff #10] to get the nurse. [Staff #9] then performed the Heimlich maneuver a second time. When [RN (Registered Nurse) #1] arrived, she determined that the suction machine was necessary to remove the food from [client C's] throat. She left [unit name] to retrieve the machine. When [RN #1] returned, [client C] had dislodged the remaining food and was breathing fine. [Staff #9], LDSP noted in the Client Injury Report dated 2/8/13 at 7:20 pm that 'client choked due to meal not being prepared properly'. [RN #1] observed [client C] and took her vitals. Additionally, Dr [name], [client C's] Primary Care Physician (PCP) was notified and an emergency chest x-ray was ordered. The x-ray indicated no issues and [client C] was not displaying any signs of distress after that incident." The investigation indicated the Administrator was notified on 02/08/13 at			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2013	
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
(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			
	7:18 PM. The Summary of Evidence indicated: "A to go tray was ordered for [client C] on 2/8/13. [Client C] was asleep during dinner time and did not go to the dining room for dinner. [Staff #11] Lead Cook prepared the to go tray, which [staff #12] sat on top of the serving line with no names written on them. [Staff #9], LDSP then picked up the trays and took them back to [unit name]. He wrote [client C's] name on her tray and placed it in the refrigerator on the hall. Later, when [client C] woke from her nap, [staff #10], DSP retrieved the container from the refrigerator and placed it on the table in front of [client C]. [Staff #10], did not open the container and check the contents. She turned away from [client C] to retrieve a spoon for her. [Staff #9], LDSP was sitting at the table, across from [client C] and was reading a new policy. [Staff #9] did not open the container and check the food to ensure that it was prepared properly. [Client C] opened the tray and began eating. [Staff #9] prompted [client C] to slow down as she was 'shoveling' her food in her mouth. [Staff #9] then told [staff #10] that the milk (sic) had not been soaked in milk. [Staff #10] then went to retrieve a cup of milk to soak [client C's] bread in. It was at this point that she (client C) choked. [Staff #9] performed the Heimlich Maneuver on [client C] twice. [Staff #10] called [RN						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2013	
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
(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			
	<p>#1] for assistance. The food was dislodged from [client C's] throat. [RN #1] assessed [client C], contacted [client C's] Physician and got an order for an emergency chest X-ray. The results of the X-ray were normal, as were all of [client C's] vital signs. Recommendations: Corrective Action for [staff #9], LDSP, [staff #12], [staff #11], Lead Cook and [staff #10], DSP for failure to ensure diet consistency was the proper consistency before meal was given to client. Train all involved staff on diet consistencies. Train all [WTS] staff on diet consistencies. Follow all current and future physician orders. Ensure that clients are properly supervised by staff during meal time. Ensure that clients are given food prepared to the proper consistency...."</p> <p>Client C's records were reviewed on 02/20/13 at 1:18 PM and contained the following dated documents:</p> <p>11/10/12: Admission Review Form indicated, "[Client C] is scheduled for admission for [name] Hall on Tuesday, November 13, 2012 at 11 am...Special Requirements. It is noted in a risk assessment for Dysphagia (difficulty in swallowing) that [client C] is at 90% risk for choking because she eats too fast & takes bites that are too large. She receives</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2013
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280		
(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	
	<p>a mechanical (pureed) diet at this time. Prior to this diet order, staff usually fed her due to this risk. Fluids are regular consistency; she uses a sippy cup with a screw-on lid for fluids...."</p> <p>11/13/12: Discharge Instructions from previous placement at time of discharge indicated client C was on a pureed diet.</p> <p>11/13/12: Admission Nursing Assessment indicated client C was on a pureed diet due to eating too fast and too big of pieces.</p> <p>11/13/12: Physician Admission Orders indicated client C was to be on a pureed diet and use a sippy cup with screw on lid.</p> <p>11/20/12: Comprehensive Nutrition Assessment - Admission Assessment indicated client C's "Diet order" was "1800 kcal (calorie) pureed." "Subjective Information indicated: Client was accompanied by her LDSP for dietary information. [Client C] indicated she liked yogurt and hasn't felt she's had any weight changes. LDSP indicated she has primarily sat with [client C] during meals and states she shovels food whether it is ground or pureed. She has not experienced s/s (signs/symptoms) of choking/aspiration with either food</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
---	--

(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
--------------------	--	---------------	---	----------------------

	<p>consistency. She brought a sippy cup with her from her previous placement but drinks fine from a regular cup. At meals she is currently receiving ground foods divided into bowls, presented to her one at a time with drinks of liquids in between. Problem Statement 1. Masticatory (muscles used in chewing) difficulty and choking risk related to inability to pace self during meals as evidenced by previous swallow study indicating 90% dysphagia risk due to shoveling of food and observed shoveling behaviors. Nutrition Goals: Goal #1: Tolerate mechanically altered (ground) diet without s/s of choking or aspiration...Goal #4: Pace self during meals and limit shoveling of food in order to decrease dysphagia risk.</p> <p>Recommendations 1. d/c (discontinue) 1800 kcal diet restriction, pureed foods, and sippy cup. 2. Change diet to regular (no calories restriction), mechanical soft with moistened ground meats, thin liquids, regular cups, food divided in high-lip bowls or use high-lip divided place. 3. Discourage pureed food at this time as client is observed 'slurping' and shoveling faster with a more liquid food consistency. 4. Provide yogurt cups PRN (as needed) between meals when client is agitated and unable to verbalize hunger. 5. Continue to provide one-on-one monitoring by LDSP at meal time to pace</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2013	
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
(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			
	<p>client appropriate and encourage paced feeding. 6. Monitor weights weekly x 4 weeks to assess adequacy of PO (oral) intake. 7. Strongly encourage SLP (Speech-Language) consult to assess dysphagia risk; follow recommendations for diet consistency per SLP recommendations. 8. Obtain occupational therapy consult for adaptive needs/utensils. Summary: [Client C] was observed by RD (Registered Dietitian) her first day in residence at lunch time. She was provided pureed foods per previous orders. Observations included losing 10-25% of food items as they were shoveled into her lap, rapid shoveling of food, and no liquids in between foods. [Client C] was later trialed (sic) on ground foods divided into high-lip bowls, presented one food item at a time, with drinks of liquid in between food items. While she still shovels, she does not 'slurp' the ground foods as she does the pureed. She has not exhibited s/s of choking and/or aspiration. At this time recommend continuing current therapy with one-on-one assistance at meals, but strongly encourage an SLP consult and swallow study, as this is beyond my scope of practice. [Client C] would benefit from a non-slip mat and possibly other adaptive equipment items. Per her history she does become agitated when she's hungry but will not verbalize hunger.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
---	--

(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
	<p>Yogurt cups will be provided and encouraged in between meals PRN...."</p> <p>11/20/12 - 12/01/12: There were no physician orders to indicate client C should be on any diet other than a pureed diet.</p> <p>12/2012: Physician Orders indicated client C was to be on an 1800 Calorie Pureed Diet with Regular Liquids and use a Sippy cup with screw on lid.</p> <p>12/27/12: Nursing Progress Notes at 4 PM indicated, "This writer noted resident was standing in the middle of the floor in the common area. 1 staff member was positioned behind pt (patient) performing the Heimlich maneuver. Staff stated 'she choked on a sandwich.' Staff attempted several times to dislodge the sandwich (sic). Resident became combative and dropped to the floor on her knees attempting to run away from staff. Staff attempted to dislodge sandwich per Heimlich maneuver. Object was successfully dislodge (sic). Resident cough (sic) several times than (sic) attempted to talk and yell. No s/s of aspiration noted at this time. Dietary notified by this nurse to change diet to pureed with thin liquids per nursing measure. No bread or sandwiches to be given. Called Medical exchange left</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
---	--

(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
	<p>message for Dr [name] to call facility re[garding] pt. Awaiting call. Res tolerated procedures well. No c/o (complaints of) pain or discomfort. Will continue to monitor."</p> <p>12/27/12: Physician Order indicated, "diet changed to pureed with thin liquids per nursing measure. No bread or sandwiches."</p> <p>12/27/12: Dietary Progress Notes at 1840 hours indicated, "[client C] had an incident tonight and choked on a piece of bread. She was currently being evaluated for appropriateness of a mechanical altered diet. Due to this incident, it is recommended that she receive pureed foods d/t (due to) continued choking risk until further evaluation by an SLP...RD will continue to follow [client C's] progress and update food consistency per SLP recommendations."</p> <p>12/28/12: Physician Order indicated, "Divided plate, weighted spoon and non-slip mat may be used for dietary purposes. May obtain chest x-ray to R/O aspiration. May obtain SLP consults with swallow study."</p> <p>12/28/12: Nursing Progress Notes at 4:30 PM indicated, "No s/s aspiration noted on x-ray results...."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2013	
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
(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			
	<p>01/2013: Physician Orders indicated client C should be on a Pureed Diet with Regular Liquids and should use a Sippy cup with screw on lid. The Orders indicated the calorie restriction was discontinued on 12/31/12.</p> <p>01/03/13: Physician Order indicated, "Add dx (diagnosis): Dysphagia."</p> <p>01/03/13: Nursing Progress Notes at 2:00 PM indicated, "Received call from [name] at [hospital] re: ST (Speech Therapy) eval[uation]. Schedule appt (appointment) for ST 1-7-13 at 9:30 AM."</p> <p>01/10/13: Medical Visit Summary from the Speech-Language Pathologist for the evaluation R/T choking indicated: "[Client C] participated in a clinical swallow evaluation ...Recommend continue thin liquids as tolerated and consider a mechanical soft diet with well-chopped or ground meats, avoid breads and dry solids. If she displays difficulty with soft foods, recommend pureed diet. If signs of aspiration (cough/choke) noted, consider swallow study."</p> <p>01/11/13: Physician Orders indicated, "Discontinue current diet orders. Thin liquids as tolerated. Mechanical Soft Diet</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2013
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280		
(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	
	<p>(MSD) with well-chopped or ground meats. Avoid breads and dry solids. If difficulty noted with soft food, recommend pureed diet. May crush meds."</p> <p>01/12/13: Hand written note by RD indicated, "Resident's diet consistency has been updated per physician's recommendations. As dry breads/solids are not allowed, broken up breads soaked in milk/broth/gravy will be provided so calories will not be lost. Will continue to follow progress and update per SLP/MD recs (recommendations)." The facility neglected to follow the client's physician's order to "Avoid breads" as the order did not indicate breads should be soaked.</p> <p>02/2013: "Physician Orders indicated client C was on Thin Liquids as Tolerated, a Mechanical Soft Diet with Well-Chopped or Ground Meats, Avoid Breads and Dry Solids, If Difficulty noted with soft foods, recommend Pureed Diet, Sippy Cup with screw on lid, Divided Plate, Weighted Spoon, and Non-Slip Mat May be used for Dietary Purposes."</p> <p>02/05/13: Clinical Therapy Note 2 PM - 3 PM indicated: "Client (C) actively participated in group today...A piece of sugar free candy was used as a reinforcer for client completion of group activities.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2013	
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
(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			
	<p>This reinforcer was also used to make choices."</p> <p>02/08/13: Progress Notes 8 AM - 4 PM indicated: "...[client C] ate 100% of lunch in dining room. [Client C] returned to unit. She went to the community kitchen and ate a little taco salad. She can back to the hall...."</p> <p>02/08/13: Nursing Progress Notes at 7:40 PM indicated: "Dr [name] notified of choking episode. All food particles removed, no respiratory distress noted at this time...Staff report client was shoveling bread and potatoes at a rapid speed...."</p> <p>02/11/13: Physician Order indicated to "1. continue MSF (mechanical soft food) diet with thin liquids. 2. No breads/dry cookies/dry foods at meal r/t dysphagia risk. 3. Provide double portion all other foods at meals r/t (related to) weight loss."</p> <p>An interview was conducted on 02/21/13 at 2:15 PM with the Health Service Coordinator (HSC). The HSC indicated client C was at risk for choking and two separate incidents had occurred which resulted in use of the Heimlich maneuver due to client C's food not being prepared according to the Physician Orders. She</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2013
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280		
(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	
	<p>indicated dietary staff neglected to follow the order when preparing the food for client C which resulted in the choking incidents. She also indicated any snacks, reinforcers or other food items should be provided within the physician orders. She indicated client C should not have been given sugar free candy as a reinforcer and she should not have eaten taco salad. The HSC further indicated prior to 02/20/13 there were no written guidelines in place for the consistency modifications of foods and liquids. The HSC indicated the investigation of the 02/08/13 incident neglected to contain all the relevant facts related to the incident. She indicated the information she received was that there were two other nurses present in the area when RN #1 left client C and went to get the suction machine. She did not know why this information was not in the investigative report and to her knowledge it was not written anywhere. She indicated a nurse should never leave a client in an emergency if he/she is the only nurse.</p> <p>The facility's policy and procedures were reviewed on 2/19/13 at 1:15 PM and 1:20 PM. The facility's 2/13/13 policy entitled Reporting and Investigations indicated "It is the policy of Warner Transitional Services (WTS) to protect individuals who may be vulnerable to abuse, neglect</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
---	--

(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
	<p>or exploitation, mistreatment, or a violation of client rights. Employees, agents and volunteers must treat clients and other individuals with dignity and respect. The neglect or abuse of any client or another individual within or outside of Warner Transitional Services will not be tolerated...." The 2/13 policy indicated "...Any employee, individual, agent or volunteer who has knowledge of the following must immediately report this information to their immediate supervisor and/or the Executive Director/Administrator: -Abuse, neglect, exploitation, mistreatment, or a violation of individual rights of a client served by any person. -Reasonable cause to believe a client has been abused (including injuries of an unknown origin), neglected mistreated, or has had his or her rights violated by any person...." The 2/13 policy also indicated "...The QSP (Qualified Support Professional) or SSP (Safety and Security Professional) will notify all appropriate WTS staff including the the Executive Director/Administrator who is responsible for ensuring that all investigations are completed thoroughly and that records of the investigation are maintained...."</p> <p>This federal tag relates to complaint #IN00117054.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2013
---	--	--	--

NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
---	--

(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
	This deficiency was cited on 10/26/12. The facility failed to implement a systemic plan of correction to prevent recurrence.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
---	--

(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
W0331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on record review and interview, the facility failed for 2 of 4 sampled clients (clients A and C) and 1 additional client (client G), by not ensuring clients received nursing services according to their medical needs, by not indicating why/when client A should wear her TED (prevent blood clots) hose, by not transcribing a new medication order correctly on MAR (Medication Administration Record) (client G), by not ensuring prescribed diet orders were followed (client C), and by not ensuring nursing services documented their presence during an emergency (client C).</p> <p>Findings include:</p> <p>1. On 02/19/13 at 2:05 PM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was completed and included the following incidents:</p> <p>02/03/13: "During the 9 PM med (medication) pass on 2/3/2013 and 2/4/2012 (sic) [client G] did not receive Topamax 200 mg (for behaviors) dose due to administration error. He was instead administered a 400 mg dose of</p>	W0331	<p>Diet Orders</p> <p>1. Corrective action(s):</p> <p>a. Client C's physician orders and adaptive equipment needs were reviewed; unnecessary devices were discontinued and all orders were clarified.</p> <p>b. Staff on the affected hall and dining staff were re-trained on diet consistencies and Client C's dining plan.</p> <p>c. Written dining plans were implemented and included in programming binders; all orders were verified by TTC, RD, QSP, HSC (DON), and MD.</p> <p>2. Prevention for other client(s):</p> <p>a. All direct care, dietary, and SSP staff trained in food consistency guidelines, modifications, and food preparations.</p> <p>b. Client-specific diet plans (for all clients) will be reviewed with all direct care, dietary, and SSP staff.</p> <p>c. All clients' medical charts, BSPs, SLP consults (if</p>	03/23/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2013
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280		
(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	
	<p>Topamax...[Administrator], was notified on 2/8/13 at 1:30 pm. Plan to Resolve: Director of Nursing will review all orders written. There will be education provided on medication transfers and writing orders."</p> <p>On 02/21/13 at 1:57 PM an interview with the Health Service Coordinator (HSC) was conducted. The HSC indicated medications that are not given as prescribed are considered medication errors as staff are not following the physician's orders. She further indicated nursing had previously made med errors of this type.</p> <p>2. 02/08/13: "[Client C] was asleep during supper and staff brought food back to the unit for her. When she awoke staff retrieved the food from the unit refrigerator. [Client C] sat next to the LDSP (Lead Direct Support Person) (unidentified staff) and began eating. Within a few minutes staff noticed the food was not prepared to the correct consistence (sic). Before they could correct the problem [client C] began choking. Staff preformed the Heimlich maneuver and the nurse was contacted to assist with the emergency. After several attempts the food was dislodged and most of it was expelled. The nurse left the unit to retrieve a suction pump but [client C]</p>		<p>applicable), and dietary assessments will be reviewed for clarifications regarding diet orders, adaptive equipment, and modified diets; physician's orders will be updated for clarifications.</p> <p>3. Measure(s) put in place for prevention:</p> <p>a. Dining plans put into place and verified by appropriate ID Team; available in programming binders and in dining area for referencing</p> <p>b. Dining policy updated (see General Dining and Snack policy, as well as Family Style Dining Policy)</p> <p>c. Dining orders will all receive physician's approval before implementation</p> <p>4. Corrective actions will be monitored:</p> <p>a. Dining plans will be updated and reviewed per quarterly review</p> <p>b. ID Team including MD, HSC(DON), RD, TTC, and QSP must all verify dining order is correct</p> <p>5. Date of implementation: 03/01/2013</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2013	
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
(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			
	<p>expelled all the material before she returned and the pump was not used. Dr [name] has been notified via phone. New order received and placed for a 'STAT' (emergency/immediate/now) chest x-ray tonight to rule out aspiration as a result of choking. Her vitals are stable and within normal range at this time. Her lungs were clear immediately following episode and oxygen saturation read 99% on room air. No other apparent signs of distress were noted or verbalized. Staff attribute this episode to [client C's] shoveling food and her food not being prepared to the correct consistency. Nursing will be following [client C's] progress over the next several days...Staff will be retrained to more consistently follow [client C's] high risk plan for choking, specifically making sure her food is prepared to the correct consistency. Staff will continue to sit next to [client C] when she eats and remind her to eat slowly and chew her food completely before attempting to swallow."</p> <p>02/15/13: Internal Investigative Report indicated: "Incident date & time: Choking 2/8/12 (sic)...On Friday, 2/8/13, [client C] was sleeping in her room on [name] Hall. Due to this, she missed dinner. [Staff #9], LDSP requested that [client C] be prepared a 'to go' tray from the kitchen This meal was prepared and</p>		<p>Medication Administration as Ordered by Physician:</p> <ul style="list-style-type: none"> · Client A's MD order for TED hose was clarified to include on in am and off in pm. Client A's edema is monitored and documented on the MAR. · This deficiency has potential to affect other clients who are ordered TED hose. · Review all care plans with MD orders for TED hose to insure clarity of order. · All nurses will be trained on Revised Medication/Treatment Policy. Health Services Coordinator reviews the triplet copies of MD order to verify orders are accurate. · Responsible Party: Health Service Coordinator: Implemented 3/23/13 				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
---	--

(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
	<p>picked up from the kitchen. [Staff #9], LDSP then placed the container with [client C's] meal inside it in the refrigerator on (client C's) [unit]. Around 7:00 pm, [client C] woke up and [staff #10], DSP (Direct Support Person) retrieved her food from the refrigerator. The food was given to [client C], who began eating it. [Staff #9], LDSP then noticed that the food was not prepared to the proper consistency. Additionally, [client C] was eating her food quickly and [staff #9] prompted [client C] to slow down. [Staff #9], LDSP then told [staff #10], DSP that the food was not the proper consistency and that [client C's] bread needs to be soaked in liquid and that this usually occurs in the kitchen before the meal is served to [client C]. As [staff #10] was preparing to soak the bread in liquid, [client C] began choking and was not breathing. [Staff #9] performed the Heimlich maneuver on [client C]. After the first attempt, there was still food hindering [client C's] ability to breath (sic). [Staff #9] told [staff #10] to get the nurse. [Staff #9] then performed the Heimlich maneuver a second time. When [RN (Registered Nurse) #1] arrived, she determined that the suction machine was necessary to remove the food from [client C's] throat. She left [unit name] to retrieve the machine. When [RN #1] returned, [client</p>		<ul style="list-style-type: none"> · Client G MAR and MD orders have been reviewed to ensure accuracy on the MAR. · Medication Order Policy was reviewed/ revised/ implemented to ensure accurate transcriptions of orders onto the MAR. All nurses will be educated on the changes of this policy. · To ensure that all other clients are not affected by this deficiency, the Health Service Coordinator or designee will get all triplet copies of all orders to verify transcriptions of orders to the MAR. · Any inaccuracies found will be immediately corrected according to the above policy. · Responsible Party: Health Services Coordinator to be implemented by 3/23/13 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
---	--

(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
	<p>C] had dislodged the remaining food and was breathing fine. [Staff #9], LDSP noted in the Client Injury Report dated 2/8/13 at 7:20 pm that 'client choked due to meal not being prepared properly'. [RN #1] observed [client C] and took her vitals. Additionally, Dr [name], [client C's] Primary Care Physician (PCP) was notified and an emergency chest x-ray was ordered. The x-ray indicated no issues and [client C] was not displaying any signs of distress after that incident." The investigation indicated the Administrator was notified on 02/08/13 at 7:18 PM. The Summary of Evidence indicated: "A to go tray was ordered for [client C] on 2/8/13. [Client C] was asleep during dinner time and did not go to the dining room for dinner. [Staff #11] Lead Cook prepared the to go tray, which [staff #12] sat on top of the serving line with no names written on them. [Staff #9], LDSP then picked up the trays and took them back to [unit name]. He wrote [client C's] name on her tray and placed it in the refrigerator on the hall. Later, when [client C] woke from her nap, [staff #10], DSP retrieved the container from the refrigerator and placed it on the table in front of [client C]. [Staff #10], did not open the container and check the contents. She turned away from [client C] to retrieve a spoon for her. [Staff #9], LDSP was sitting at the table, across from [client</p>		<p>Nursing Presence Documented During an Emergency</p> <ul style="list-style-type: none"> · All residents could be affected in an emergency situation where nursing presence is not documented. · Corrective action to prevent this in the future includes all nurses will be reeducated on importance of documentation of presence in an emergency situation and completing a witness statement. · All witness statements completed by nursing will be submitted to HSC. · Responsible Party: Health Services Coordinator Implemented by 3/23/13 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2013	
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
(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			
	<p>C] and was reading a new policy. [Staff #9] did not open the container and check the food to ensure that it was prepared properly. [Client C] opened the tray and began eating. [Staff #9] prompted [client C] to slow down as she was 'shoveling' her food in her mouth. [Staff #9] then told [staff #10] that the milk (sic) had not been soaked in milk. [Staff #10] then went to retrieve a cup of milk to soak [client C's] bread in. It was at this point that she (client C) choked. [Staff #9] performed the Heimlich Maneuver on [client C] twice. [Staff #10] called [RN #1] for assistance. The food was dislodged from [client C's] throat. [RN #1] assessed [client C], contacted [client C's] Physician and got an order for an emergency chest X-ray. The results of the X-ray were normal, as were all of [client C's] vital signs. Recommendations: Corrective Action for [staff #9}, LDSP, [staff #12], [staff #11], Lead Cook and [staff #10], DSP for failure to ensure diet consistency was the proper consistency before meal was given to client. Train all involved staff on diet consistencies. Train all [WTS] staff on diet consistencies. Follow all current and future physician orders. Ensure that clients are properly supervised by staff during meal time. Ensure that clients are given food prepared to the proper consistency...."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
---	--

(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
	<p>Client C's records were reviewed on 02/20/13 at 1:18 PM and contained the following dated documents:</p> <p>11/10/12: Admission Review Form indicated, "[Client C] is scheduled for admission for [name] Hall on Tuesday, November 13, 2012 at 11 am...Special Requirements. It is noted in a risk assessment for Dysphagia (difficulty in swallowing) that [client C] is at 90% risk for choking because she eats too fast & takes bites that are too large. She receives a mechanical (pureed) diet at this time. Prior to this diet order, staff usually fed her due to this risk. Fluids are regular consistency; she uses a sippy cup with a screw-on lid for fluids...."</p> <p>11/13/12: Discharge Instructions from previous placement at time of discharge indicated client C was on a pureed diet.</p> <p>11/13/12: Admission Nursing Assessment indicated client C was on a pureed diet due to eating too fast and too big of pieces.</p> <p>11/13/12: Physician Admission Orders indicated client C was to be on a pureed diet and use a sippy cup with screw on lid.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2013	
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
(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			
	<p>11/20/12: Comprehensive Nutrition Assessment - Admission Assessment indicated client C's "Diet order" was "1800 kcal (calorie) pureed." "Subjective Information indicated: Client was accompanied by her LDSP for dietary information. [Client C] indicated she liked yogurt and hasn't felt she's had any weight changes. LDSP indicated she has primarily sat with [client C] during meals and states she shovels food whether it is ground or pureed. She has not experienced s/s (signs/symptoms) of choking/aspiration with either food consistency. She brought a sippy cup with her from her previous placement but drinks fine from a regular cup. At meals she is currently receiving ground foods divided into bowls, presented to her one at a time with drinks of liquids in between. Problem Statement 1. Masticatory (muscles used in chewing) difficulty and choking risk related to inability to pace self during meals as evidenced by previous swallow study indicating 90% dysphagia risk due to shoveling of food and observed shoveling behaviors. Nutrition Goals: Goal #1: Tolerate mechanically altered (ground) diet without s/s of choking or aspiration...Goal #4: Pace self during meals and limit shoveling of food in order to decrease dysphagia risk. Recommendations 1. d/c (discontinue)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2013	
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
(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			
	<p>1800 kcal diet restriction, pureed foods, and sippy cup. 2. Change diet to regular (no calories restriction), mechanical soft with moistened ground meats, thin liquids, regular cups, food divided in high-lip bowls or use high-lip divided place. 3. Discourage pureed food at this time as client is observed 'slurping' and shoveling faster with a more liquid food consistency. 4. Provide yogurt cups PRN (as needed) between meals when client is agitated and unable to verbalize hunger. 5. Continue to provide one-on-one monitoring by LDSP at meal time to pace client appropriate and encourage paced feeding. 6. Monitor weights weekly x 4 weeks to assess adequacy of PO (oral) intake. 7. Strongly encourage SLP (Speech-Language) consult to assess dysphagia risk; follow recommendations for diet consistency per SLP recommendations. 8. Obtain occupational therapy consult for adaptive needs/utensils. Summary: [Client C] was observed by RD (Registered Dietitian) her first day in residence at lunch time. She was provided pureed foods per previous orders. Observations included losing 10-25% of food items as they were shoveled into her lap, rapid shoveling of food, and no liquids in between foods. [Client C] was later trialed (sic) on ground foods divided into high-lip bowls, presented one food item at a time, with</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
---	--

(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
	<p>drinks of liquid in between food items. While she still shovels, she does not 'slurp' the ground foods as she does the pureed. She has not exhibited s/s of choking and/or aspiration. At this time recommend continuing current therapy with one-on-one assistance at meals, but strongly encourage an SLP consult and swallow study, as this is beyond my scope of practice. [Client C] would benefit from a non-slip mat and possibly other adaptive equipment items. Per her history she does become agitated when she's hungry but will not verbalize hunger. Yogurt cups will be provided and encouraged in between meals PRN...."</p> <p>11/20/12 - 12/01/12: There were no physician orders to indicate client C should be on any diet other than a pureed diet.</p> <p>12/2012: Physician Orders indicated client C was to be on an 1800 Calorie Pureed Diet with Regular Liquids and use a Sippy cup with screw on lid.</p> <p>12/27/12: Nursing Progress Notes at 4 PM indicated, "This writer noted res[ident] was standing in the middle of the floor in the common area. 1 staff member was positioned behind pt (patient) performing the Heimlich maneuver. Staff stated 'she choked on a</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2013	
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
(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			
	<p>sandwich.' Staff attempted several times to dislodge the sandwich (sic). Resident became combative and dropped to the floor on her knees attempting to run away from staff. Staff attempted to dislodge sandwich per Heimlich maneuver. Object was successfully dislodge (sic). Resident cough (sic) several times than (sic) attempted to talk and yell. No s/s of aspiration noted at this time. Dietary notified by this nurse to change diet to pureed with thin liquids per nursing measure. No bread or sandwiches to be given. Called Medical exchange left message for Dr [name] to call facility re[garding] pt. Awaiting call. Res tolerated procedures well. No c/o (complaints of) pain or discomfort. Will continue to monitor."</p> <p>12/27/12: Physician Order indicated, "diet changed to pureed with thin liquids per nursing measure. No bread or sandwiches."</p> <p>12/27/12: Dietary Progress Notes at 1840 hours indicated, "[client C] had an incident tonight and choked on a piece of bread. She was currently being evaluated for appropriateness of a mechanical altered diet. Due to this incident, it is recommended that she receive pureed foods d/t (due to) continued choking risk until further evaluation by an SLP...RD</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
---	--

(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
	<p>will continue to follow [client C's] progress and update food consistency per SLP recommendations."</p> <p>12/28/12: Physician Order indicated, "Divided plate, weighted spoon and non-slip mat may be used for dietary purposes. May obtain chest x-ray to R/O aspiration. May obtain SLP consults with swallow study."</p> <p>12/28/12: Nursing Progress Notes at 4:30 PM indicated, "No s/s aspiration noted on x-ray results...."</p> <p>01/2013: Physician Orders indicated client C should be on a Pureed Diet with Regular Liquids and should use a Sippy cup with screw on lid. The Orders indicated the calorie restriction was discontinued on 12/31/12.</p> <p>01/03/13: Physician Order indicated, "Add dx (diagnosis): Dysphagia."</p> <p>01/03/13: Nursing Progress Notes at 2:00 PM indicated, "Received call from [name] at [hospital] re: ST (Speech Therapy) eval[uation]. Schedule appt (appointment) for ST 1-7-13 at 9:30 AM."</p> <p>01/10/13: Medical Visit Summary from the Speech-Language Pathologist for the evaluation R/T choking indicated:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2013	
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
(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			
	<p>"[Client C] participated in a clinical swallow evaluation ...Recommend continue thin liquids as tolerated and consider a mechanical soft diet with well-chopped or ground meats, avoid breads and dry solids. If she displays difficulty with soft foods, recommend pureed diet. If signs of aspiration (cough/choke) noted, consider swallow study."</p> <p>01/11/13: Physician Orders indicated, "Discontinue current diet orders. Thin liquids as tolerated. Mechanical Soft Diet (MSD) with well-chopped or ground meats. Avoid breads and dry solids. If difficulty noted with soft food, recommend pureed diet. May crush meds."</p> <p>01/12/13: Hand written note by RD indicated, "Resident's diet consistency has been updated per physician's recommendations. As dry breads/solids are not allowed, broken up breads soaked in milk/broth/gravy will be provided so calories will not be lost. Will continue to follow progress and update per SLP/MD recs (recommendations)." The facility did not follow the client's physician's order to "Avoid breads" as the order did not indicate breads should be soaked.</p> <p>02/2013: Physician Orders indicated</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
---	--

(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
	<p>client C was on "Thin Liquids as Tolerated, a Mechanical Soft Diet with Well-Chopped or Ground Meats, Avoid Breads and Dry Solids, If Difficulty noted with soft foods, recommend Pureed Diet, Sippy Cup with screw on lid, Divided Plate, Weighted Spoon, and Non-Slip Mat May be used for Dietary Purposes."</p> <p>02/05/13: Clinical Therapy Note 2 PM - 3 PM indicated: "Client (C) actively participated in group today...A piece of sugar free candy was used as a reinforcer for client completion of group activities. This reinforcer was also used to make choices."</p> <p>02/08/13: Progress Notes 8 AM - 4 PM indicated: "...[client C] ate 100% of lunch in dining room. [Client C] returned to unit. She went to the community kitchen and ate a little taco...."</p> <p>02/08/13: Nursing Progress Notes at 7:40 PM indicated: "Dr [name] notified of choking episode. All food particles removed, no respiratory distress noted at this time...Staff report client was shoveling bread and potatoes at a rapid speed...."</p> <p>02/11/13: Physician Order indicated to "1. continue MSF (mechanical soft food) diet with thin liquids. 2. No breads/dry</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2013	
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
(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			
	<p>cookies/dry foods at meal r/t dysphagia risk. 3. Provide double portion all other foods at meals r/t (related to) weight loss."</p> <p>An interview was conducted on 02/21/13 at 2:15 PM with the Health Service Coordinator (HSC). The HSC indicated client C was at risk for choking and two separate incidents had occurred which resulted in use of the Heimlich maneuver due to client C's food not being prepared according to the Physician Orders. The HSC indicated the investigation of the 02/08/13 incident failed to contain all the relevant facts related to the incident. She indicated the information she received was that there were two other nurses present in the area when RN #1 left client C and went to get the suction machine. She did not know why this information was not in the investigative report and to her knowledge it was not written anywhere.</p> <p>3. During the 2/19/13 observation period between 3:25 PM and 6:00 PM, at the facility, client A wore house shoes with bare legs/feet around the unit. Client A's left ankle was swollen. Client A did not wear nor was she encouraged to wear Ted Hose (compression stockings).</p> <p>Client A's record was reviewed on</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2013
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280		
(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	
	<p>2/21/13 at 11:02 AM. Client A's 11/27/12 Client Information Form indicated client A "Wears Compression Stocking on her left leg during awake hours."</p> <p>Client A's 2/1/13 physician's orders indicated client A had an order to wear knee high TED hose/Support Stocking on her left leg. The 2/1/13 physician orders indicated "Use as directed." Client A's 2/1/13 physician's orders indicated client A's diagnoses included, but were not limited to, Hypertension and Blood Clots for which the client received routine medications for.</p> <p>Client A's 2/1/13 to 2/121/13 Nursing Progress Notes indicated the following (not all inclusive):</p> <p>-1/23/13 "Late entry. On 1/21/13 at 9:00 PM client C/O (complained of) swelling in legs. Slight edema noted on calves: bilaterally. Skin on LE (lower extremity) WNL (within normal limits) & (and) equal. Client was not wearing TED hose on L (left) leg. When asked why she was not wearing it, she stated she threw them away because she was angry."</p> <p>-1/26/13 "C/O swollen ankles of leg. Measure and circumference @ (at) achille tendon to midline of front leg is 27 cm</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
---	--

(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
	<p>(centimeters). Ice and elevation initiated. Will reevaluate in 10 mins (minutes)." No additional monitoring and/or follow-up was documented.</p> <p>Client A's Nursing Progress Notes did not indicate any additional monitoring and/or documentation of client A's edema and/or TED hose usage for client A's edema/swelling as ordered.</p> <p>Client A's Undated Health Risk Plan for Blood Clots and/or client A's risk plan for Hypertension did not indicate when client A should wear the ordered TED hose. Client A's undated Health Risk Plans and/or client A's 2/13 physician's orders indicated the facility's nursing services failed to document and/or obtain clarification on when client A was to wear the prescribed TED hose to prevent edema.</p> <p>Interview with the Health Services Coordinator (HSC) on 2/21/13 at 4:20 PM indicated client A had history of blood clots. The HSC indicated client A was to wear TED hose for the client's edema. When asked how client A's edema was monitored, the HSC stated "Nurse should document when problem occurs in nurse notes." The HSC indicated client A's 2/13 physician's order did not specifically indicate when client A</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
---	--

(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
--------------------	--	---------------	---	----------------------

	<p>should wear the ordered TED hose. The HSC indicated client A's risk plans for Hypertension and/or Blood Clots should indicate when/how often client A should wear the ordered TED hose to prevent edema. The HSC indicated the facility's nurses should have sought clarification in regard to the 2/1/13 physician's order.</p> <p>This federal tag relates to complaint #IN00117054.</p> <p>This deficiency was cited on 10/26/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/21/2013	
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
(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			
W0368	<p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>Based on record review and interview, the facility failed for 1 additional client (client G) who takes medications prescribed by the physician, to administer medications as ordered.</p> <p>Findings include:</p> <p>On 02/19/13 at 2:05 PM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was completed and included the following medication error:</p> <p>02/03/13: "During the 9 PM med (medication) pass on 2/3/2013 and 2/4/2012 (sic) [client G] did not receive Topamax 200 mg (for behaviors) dose due to administration error. He was instead administered a 400 mg dose of Topamax...[Administrator], was notified on 2/8/13 at 1:30 pm. Plan to Resolve: Director of Nursing will review all orders written. There will be education provided on medication transfers and writing orders."</p> <p>On 02/21/13 at 1:57 PM an interview with the Health Service Coordinator</p>	W0368	<p>Medication Administration:</p> <ul style="list-style-type: none"> · Client G MAR and MD orders have been reviewed to ensure accuracy on the MAR. · Medication Order Policy was reviewed/revised/implemented to ensure accurate transcriptions of orders onto the MAR. All nurses will be educated on the changes of this policy. · To ensure that all other clients are not affected by this deficiency, the Health Service Coordinator or designee will get all triplet copies of all orders to verify transcriptions of orders to the MAR. · Any inaccuracies found will be immediately corrected according to the above policy. · Responsible Party: Health Services Coordinator to be implemented by 3/23/13 	03/23/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
---	--

(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
	<p>(HSC) was conducted. The HSC indicated medications that are not given as prescribed are considered medication errors as staff are not following the physician's orders. She further indicated nursing had previously made med errors of this type. She indicated currently there was not a completed nursing policy and procedure book and there was not a policy on how to transcribe new medication orders on the MAR (Medication Administration Record).</p> <p>This deficiency was cited on 10/26/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>			