STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G401	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL SERVICES SUB LLC	1603 S LYNHURST DR INDIANAPOLIS, IN 46241

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W 0000 Bldg. 00	This visit was for the fundamental annual recertification and state licensure survey. Dates of Survey: July 21, 22, 23, 24 and 27, 2015. Facility Number: 000915 Provider Number: 15G401 AIMS Number: 100244390 These deficiencies also reflect state findings in accordance with 460 IAC 9.	W 0000		
W 0369 Bldg. 00	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review and interview for 1 of 18 medications observed being administered, the facility failed to ensure all medications were administered without error to client #1. Findings include: Observations were conducted at the group home on 7/22/15 between 5:45	W 0369	Facility Nurse will retrain staff on following physician instructions for client #1 Chlorhexidine rinse administration and the consumption of food and drink. Facility Nurse will retrain staff on medication administration procedures; including, specific administration time orders for all clients. Program Coordinator will complete medication observations at least 3 times weekly for 30 days to ensure	08/26/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	AM and 7:45 AM. __At 6:44 AM client #1 was given Chlorhexidine mouth rinse. Immediately after spitting out his mouthwash client #1 was prompted to sit at the dining room table for his morning meal. __At 6:51 AM client #1 had completed his morning meal. Client #1's July 2015 Medication Administration Record (MAR) was reviewed on 7/22/15 at 8 AM. The MAR indicated client #1 was not to eat or drink for 30 minutes after receiving his Chlorhexidine mouth rinse. Client #1's record was reviewed on 7/22/15 at 1 PM. Client #1's 6/24/15 physician's orders indicated client #1 was to receive Chlorhexidine rinse at 6:30 AM and was not to eat or drink for 30 minutes following use. During interview with the Qualified Intellectual Disabilities Professional (QIDP) on 7/22/15 at 8:05 AM, the QIDP indicated all medications were to be given as ordered by the physician and as indicated on the client's MAR. 9-3-6(a)		compliance with medication administration. Ongoing, Program Coordinator will complete medication administration observations at least once a weekly to ensure compliance with medication administration.	

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W 0455 Bldg. 00	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation and interview for 2 of 4 sampled clients (#1 and #3), the facility failed to ensure the facility owned day services maintained proper hygiene practices to prevent cross contamination of germs. Findings include: Observations and interviews were conducted at the facility owned Day Program (DP) on 7/21/15 between 10:15 AM and 11:15 AM. __At 10:20 AM the DP Program Coordinator (PC) indicated 25 clients were in attendance at the day program during this observation period. __At 10:30 AM the DP PC stated the lunch boxes were stored in the "cubby room," a small room adjacent to the main room of the DP. The DP PC opened the door to the "cubby room." The clients' lunch boxes at the DP were piled in a large heap on the floor. The PC immediately began picking the lunch boxes up and placing them in a large ottoman style black box. __Clients #1 and #3 were observed eating their lunch during this observation period.	W 0455	Area Director will retrain staff on proper universal precautions and infectious control for the prevention of spreading germs;including, proper usage of gloves when assisting clients, proper hand washing for staff and clients prior to a mealtime, proper sanitation of tables in between eating and providing appropriate dinnerware when serving client lunches. Staff will also be trained on providing clients with adequate cleaning materials to clean themselves after a meal. In combination, Program Coordinator and Area Director will complete mealtime observations at least 4 times weekly for 30 days to ensure universal precautions and infectious control practices are followed per regulations and as trained. Ongoing, Program Coordinator will complete meal time observation at least 3 times weekly. Area Director will retrain staff on appropriately placing consumer lunch boxes in established storage unit and lunches requiring refrigeration stored in the refrigerator. Area Director will order an additional refrigerator to accommodate for additional storage needed for consumer lunch boxes.	08/26/2015

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	__Clients #1 and #3 were not prompted to wash their hands and/or provided a hand sanitizer prior to eating their lunch. __Clients #1 and #3 lay their bologna sandwiches directly on the dining room table while eating. The staff did not provide clients #1 and #3 a plate and/or prompt the clients not to place their food on the table. __Three staff were in and out of the lunchroom assisting multiple clients and feeding two of the clients in the room with clients #1 and #3. The staff moved from client to client touching clients' food and dinnerware. The staff did not wash and/or sanitize their hands between clients while assisting clients #1 and #3 with their meals. __Clients #1 and #3 were not provided napkins to wipe their hands or face. Client #3 wiped his hands on his pant legs. During interview with the DP PC on 7/21/15 at 11:15 AM, the PC: __Indicated there was insufficient space at the DP to store the lunch boxes. __Indicated the clients' lunch boxes should not be thrown on the floor. __Indicated clients #1 and #3 should have been provided a paper plate to lay their sandwich on while eating and the clients prompted not to lay their food directly on the dining table.			

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	__Indicated the clients were to be provided a napkin when eating and prompted to wipe their hands and face if needed. __Indicated all clients were to be prompted and/or assisted to wash their hands prior to eating. __Indicated the staff were to wash and/or sanitize their hands after assisting each client. 9-3-7(a)			
W 0460 Bldg. 00	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, record review and interview for 1 of 4 sampled clients (#1), the facility failed to ensure client #1 was provided the physician ordered double portions for his lunch meal. Findings include: Observations were conducted at the facility owned Day Program (DP) on 7/21/15 between 10:15 AM and 11:15 AM. Client #1 was tall and thin. Clients #1 and #3 attended the same day program. Both clients were provided a	W 0460	Program Coordinator will retrain staff on following client#1 dieting plan and packing adequate double food portions when sending prepared lunch to day programming. PC will also review client #1 dieting plan with the day Program Coordinator Program Coordinator will also review dieting plan for all other clients to ensure adequate portions are packed when preparing lunches offsite. Day Program Coordinator and staff will check client #1 lunch daily to verify adequate portions have been sent. In the event that portion sizes do not meet dietary requirements, the day program	08/26/2015

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	bologna sandwich (two slices of bread with one slice of bologna), a snack pack of crackers, a snack pack of applesauce and a juice drink for their afternoon meal. Client #1 was not provided and/or offered double portions for his lunch. Client #1's record was reviewed on 7/22/15 at 1 PM. Client #1's physician's orders dated 6/24/15 indicated client #1 was to be provided extra portions for lunch. Client #1's 6/1/15 dietary assessment indicated client #1 was to maintain his current weight and was to be offered extra portions. The QIDP (Qualified Intellectual Disabilities Professional) and the HM were interviewed on 7/23/15 at 3 PM. The QIDP and the HM indicated client #1 was to have double portions packed in his lunch box every day for day program. 9-3-8(a)		will supplement the meal as needed.	
W 0475 Bldg. 00	483.480(b)(2)(iv) MEAL SERVICES Food must be served with appropriate utensils. Based on observation, interview and record review for 4 of 4 sampled clients (#1, #2, #3 and #4) and 2 additional	W 0475	Program Director will retrain staff on providing appropriate utensils at mealtime for food served; including knives. Program	08/26/2015

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	clients (#5 and #7), the facility failed to ensure the clients were provided a knife to cut their pork steak during their evening meal and clients #1 and #3 were provided dinnerware to place their sandwich on while at Day Program (DP). Findings include: Observations were conducted at the group home on 7/21/15 between 4:15 PM and 6 PM. __The clients were served pork steaks, coleslaw, beets and applesauce for their evening meal. __Clients #3 and #5 set the table. __No knives were placed on the table. __At 5:18 PM clients #1, #2, #3, #4 and #5 sat down at the table for their evening meal. Each client took one pork steak from the platter and placed it on their plates. __Clients #1, #2, #3 and #5 picked up their pork steak to eat with their hands. __Client #4 stabbed the whole pork steak with a fork and ate it. __Client #7 returned home from work and joined his housemates for the evening meal. Client #7 also stabbed the whole pork steak with a fork and ate it. __Clients #1, #2, #3, #4, #5 and #7 were not provided a knife to cut their meat into bite size pieces. __At 5:30 PM after asking staff why		Coordinator will complete residential mealtime observations at least 3 times weekly for 30 days to ensure appropriate utensils are served during mealtime. Ongoing, Program Coordinator will complete mealtime observations at least once weekly. Area Director will train day program on providing appropriate dinnerware when serving client lunches. In combination, Program Coordinator and Area Director will complete day program mealtime observations at least 4 times weekly for 30 days. Ongoing, Day Program Coordinator will complete mealtime observation at least 3 times weekly.	

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	there were no knives on the table for the clients to cut their steak, one of the staff went to the kitchen and returned with knives and placed them on the table. Staff #1 then cut client #5's pork steak into smaller pieces for her. Observations were conducted at the facility owned DP on 7/21/15 between 10:15 AM and 11:15 AM. __Clients #1 and #3 were provided a bologna sandwich, a snack pack of crackers, a snack pack of applesauce and a juice drink for their afternoon meal. __Client #1 was blind. At 10:46 AM client #1 was guided into the dining area and prompted to sit down at one of the tables. The staff emptied the contents of client #1's lunch box onto the dining room table, opened all of the containers including the plastic bag with the bologna sandwich and then left client #1 to help other clients. Client #1's bologna sandwich was placed on the table. __At 11:05 AM client #3 entered the lunchroom. A staff emptied the contents of client #3's lunch box onto the dining room table, opened all of the containers including the plastic bag with the bologna sandwich and then left client #3 to help other clients. Client #3 lay his sandwich down on the table. __Clients #1 and #3 were not provided dinnerware to place their sandwich on.			

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	During interview with the DP Program Coordinator (PC) on 7/21/15 at 11:15 AM, the PC: __Indicated the staff were to provide the clients with the appropriate dinnerware at every meal. __Indicated clients #1 and #3 should have been provided a paper plate or a paper towel to lay their sandwich on. The Qualified Intellectual Disabilities Professional (QIDP) and the Home Manager (HM) were interviewed on 7/23/15 at 3 PM. The QIDP and the HM indicated clients are to be provided appropriate dinnerware for every meal. 9-3-8(a)			
W 0488 Bldg. 00	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview for 2 of 3 sampled clients (#1 and #3), the facility failed to ensure the staff oriented client #1 to what food was being served and the location of his food prior to eating and to include clients #1 and #3 with their meal preparation and clearing	W 0488	Program Coordinator will train staff on orientating client#1 to his food prior to eating his meal. This will include the location of his food and identify the location of items using hand over hand. Program Coordinator will retrain staff on providing effective active treatment to include, involvement	08/26/2015

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	the table after eating. Findings include: Observations were conducted at the facility owned Day Program (DP) on 7/21/15 between 10:15 AM and 11:15 AM. __Clients #1 and #3 were observed eating their afternoon meal during this observation period. __Client #1 was blind. __At 10:46 AM client #1 was guided into the dining room area and prompted to sit down at one of the tables. The staff emptied the contents of client #1's lunch box onto the dining room table, opened all of the containers including the plastic bag with the bologna sandwich and then left client #1 to help other clients. __The staff did not speak with client #1 while opening the contents of his lunchbox and did not inform client #1 what he was having for lunch and/or the location of the items on the table. __At 11:05 AM client #3 entered the lunchroom. A staff emptied the contents of client #3's lunch box onto the dining room table and left client #3 to help other clients. __The staff were in and out of the lunch room assisting multiple clients. __No one spoke to clients #1 or #3 while they ate their meals.		in training opportunities of meal preparation , clean-up based on functioning level and ongoing client interaction. Ongoing, Program Coordinator will complete active treatment and mealtime observations at least 3 times weekly to ensure proper implementation.	

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	__Client #1 finished his lunch at 11:07 AM and sat with his legs crossed and his hand in his head. __At 11:12 AM a staff cleared client #1's trash from the table and stated, "I'm cleaning your mess up and I'll be back to get you in a minute." __At 11:15 AM client #1 was escorted out of the dining room. __Client #3 finished his lunch at 11:17 AM, wiped his hands on his pant leg, got up from the dining room table and left the room. __Staff cleared client #3's trash from the table. __Clients #1 and #3 were not prompted to assist with preparing their lunches and/or to clear the tables once finished eating. __The staff did not provide clients #1 and #3 with a napkin while eating their lunch and/or directly supervise the clients while eating. During interview with the DP Program Coordinator (PC) on 7/21/15 at 11:15 AM, the PC: __Indicated the staff were to directly supervise and assist the clients during lunch. __Indicated client #1 was to be oriented to what he was being served and the location of the items on the table. __Indicated clients #1 and #3 should			

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	have been provided napkins and prompted to wipe their face and hands as needed. 9-3-8(a)			