

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401
---	--

(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 a fundamental annual recertification and state licensure survey.</p> <p>This visit was in conjunction with the post certification revisit to the investigation of complaint #IN00100018.</p> <p>Survey dates: January 23, 24, 26 and 27, 2012.</p> <p>Facility number: 000823 Provider number: 15G304 AIM number: 100249090</p> <p>Surveyor: Steven Schwing, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/9/12 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:  15G304		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012	
NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401			
(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>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview for 2 of 4 clients in the sample (F and G), the governing body failed to ensure the clients did not pay for their own haircuts.</p> <p>Findings include:</p> <p>A review of the clients' finances was conducted on 1/27/12 at 9:27 AM (for August 2011). On 8/22/11, client F paid \$12.00 for a haircut out of his checking account. There was no documentation in his financial records indicating client F was reimbursed. On 8/29/11, client G paid \$12.00 for a haircut out of his checking account. There was no documentation in his financial records indicating client G was reimbursed.</p> <p>The facility did not provide a policy addressing haircuts. A forwarded email from Administrative Staff (AS) #1, dated 1/27/12, indicated the following from AS #4, "I don't have access to the tdrive right now, but my understanding is that we pay for the basic minimum haircuts and shampoo, soap per the Medicaid guidelines. Not sure it is specific outlined in any policy ...except that we follow the Medicaid guidelines."</p>	W0104	<p>The Program Director and Home Manager were retrained on Medicaid Guidelines pertaining specifically to personal hygiene and haircuts on 1/27/2012. Clients F and G were reimbursed for the cost of their haircuts on 2/20/2012. The Program Director will monitor client accounts monthly to ensure there are no expenses that TSI is responsible for paying. Responsible Party: Home Manager, Program Director, Area Director.</p>	02/26/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401
---	--

(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>An interview with AS #3 was conducted on 1/27/12 at 9:23 AM. AS #3 indicated the facility should pay for haircuts.</p> <p>An interview with the Home Manager (HM) was conducted on 1/27/12 at 9:23 AM. The HM indicated the facility should pay for haircuts. The HM indicated the clients were not reimbursed for the haircuts.</p> <p>9-3-1(a)</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012	
NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401			
(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			
W0125	<p>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, interview and record review for 8 of 8 clients living in the group home (A, B, C, D, E, F, G and H), the facility failed to ensure the clients had the right to due process in regard to:</p> <p>1) a locked thermostat and 2) client E's possessions being searched without written permission.</p> <p>Findings include:</p> <p>1) Observations were conducted at the group home on 1/23/12 from 3:54 PM to 5:28 PM and 1/24/12 from 5:56 AM to 7:36 AM. During the observations, the thermostat was locked with a plastic cover. The cover was unable to be removed without unlocking the lock with a key. This affected clients A, B, C, D, E, F, G and H.</p> <p>A review of client A's record was conducted on 1/24/12 at 10:53 AM. There was no documentation in his record indicating the thermostat needed to be locked.</p> <p>A review of client B's record was conducted on 1/24/12 at 10:59 AM.</p>	W0125	<p>The lock on the thermostat has been removed. The Program Director received retraining on notifying clients and the guardians, if applicable, of any restrictions or possible limitations to items or programs prior to the restriction being implemented. All restrictions will be approved by applicable team members and HRC and will be included in each client's annual plan. The Home Manager was retrained on following client's written plans and restrictions that have been approved by the client, their team, guardian, if applicable, and the HRC, and not implementing any other restrictions (i.e. searching a client's possessions) that have not been approved and are not part of the client's plan on 1/27/2012. Client E's plan has been updated and revised to include a plan for returning library items timely and paying any fees that were incurred from past library bills due to overdue items, a damaged item, replacement costs for items and collection agency costs. Staff were trained on 1/31/2012 on Client E's updated plan regarding library items. The Home Manager and Program Director will monitor weekly that Client E's library plan</p>	02/26/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012	
NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401			
(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>There was no documentation in his record indicating the thermostat needed to be locked.</p> <p>A review of client C's record was conducted on 1/24/12 at 11:20 AM. There was no documentation in his record indicating the thermostat needed to be locked.</p> <p>A review of client D's record was conducted on 1/24/12 at 11:09 AM. There was no documentation in his record indicating the thermostat needed to be locked.</p> <p>A review of client E's record was conducted on 1/24/12 at 10:46 AM. There was no documentation in his record indicating the thermostat needed to be locked.</p> <p>A review of client F's record was conducted on 1/24/12 at 11:33 AM. There was no documentation in his record indicating the thermostat needed to be locked.</p> <p>A review of client G's record was conducted on 1/24/12 at 11:44 AM. There was no documentation in his record indicating the thermostat needed to be locked.</p>		is being followed. Responsible Party: Home Manager, Program Director, Area Director				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012	
NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>A review of client H's record was conducted on 1/24/12 at 12:04 PM. There was no documentation in his record indicating the thermostat needed to be locked.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 1/24/12 at 11:31 AM. AS #1 indicated the thermostat should not be locked. On 1/26/12 at 12:58 PM, AS #1 indicated AS #1 and the maintenance staff had the 2 keys to the locked thermostat cover. He indicated there were no other keys to the locked thermostat cover.</p> <p>2a) A review of the clients' finances was conducted on 1/24/12 at 10:36 AM. On 1/20/12, client F had a deposit into his account from client E for the amount of \$85.00 for the repayment of client E stealing client F's cellphone. The entry on the January 2012 Check Register Record indicated, "[client E] paying back [client F] for stealing phone!!"</p> <p>A review of the facility's incident/investigative reports was conducted on 1/23/12 at 1:18 PM. There were no incident or investigative reports for review regarding client F's cellphone being stolen by client E.</p> <p>A review of client E's record was</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012
NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401		
(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>conducted on 1/24/12 at 10:46 AM. There was no documentation in his record indicating there was a plan for staff to periodically search his room or possessions.</p> <p>An interview with the Home Manager (HM) was conducted on 1/27/12 at 9:23 AM. The HM indicated client F initially reported he lost his cellphone but suspected client E took it. The HM indicated she could not verify this occurred until, months later, she found the cellphone in client E's dresser drawer. Client E denied taking the phone. The HM indicated she did not document her interviews.</p> <p>2b) A review of client E's financial records was conducted on 1/24/12 at 10:36 AM. On 9/1/11 client E paid the public library \$129.17. The Description of Purchase indicated "paying bill." On 11/14/11 client E paid the public library \$43.08. The Description of Purchase indicated "paying off bill." A review of the bill, dated 1/26/12, indicated client E's fees were related to overdue items, damaged item, replacement costs for items and collection agency costs.</p> <p>A review of client E's record was conducted on 1/24/12 at 11:13 AM. There was no documentation in his record</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012
NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401		
(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>indicating there was a plan for items borrowed from the library.</p> <p>An interview with AS #1 was conducted on 1/26/12 at 12:58 PM. AS #1 indicated client E's repayment to the library addressed overdue fees and replacement costs for compact discs he sold to other clients. AS #1 indicated there was no plan addressing client E's borrowing items from the library.</p> <p>An interview with the HM was conducted on 1/27/12 at 9:23 AM. The HM indicated client E would get the bills from the library and throw them away before staff could see the bills. The HM indicated she found out client E owed money to the library while searching his dresser drawers. The HM indicated there was no plan in place addressing items borrowed from the library.</p> <p>9-3-2(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012	
NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401			
(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
W0140	<p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients.</p> <p>Based on record review and interview for 8 of 8 clients living in the group home (A, B, C, D, E, F, G and H), the facility failed to ensure the clients did not incur service charges on their checking accounts.</p> <p>Findings include:</p> <p>A review of the clients' finances was conducted on 1/24/12 at 10:36 AM. The clients incurred the following services charges on their checking accounts:</p> <p>-Client A: 7/26/11 - \$6.00, 8/23/11 - \$6.00, 9/26/11 - \$6.00, 10/25/11 - \$6.00, 11/25/11 - \$6.00, and 12/23/11 - \$ \$6.00. -Client B: 7/27/11 - \$6.00, 8/24/11 - \$6.00, 9/27/11 - \$6.00, and 10/27/11 - \$6.00. -Client C: 7/27/11 - \$12.00, 8/24/11 - \$12.00, 9/27/11 - \$12.00, 10/27/11 - \$12.00, 11/28/11 - \$12.00, and 12/27/11 - \$12.00. -Client D: 7/15/11 - \$6.00, 8/12/11 - \$6.00, 9/15/11 - \$6.00, 10/17/11 - \$6.00, 11/15/11 - \$6.00, and 12/14/11 - \$6.00. -Client E: 7/14/11 - \$6.00, 8/11/11 - \$6.00, 9/14/11 - \$6.00, 10/14/11 - \$6.00, 11/14/11 - \$6.00, and 12/13/11 - \$6.00. -Client F: 7/20/11 - \$6.00, 8/17/11 - \$6.00, 9/20/11 - \$6.00, 10/20/11 - \$6.00, 11/18/11 - \$6.00, and 12/19/11 - \$6.00.</p>			W0140	<p>All clients' checking accounts have been transferred to another bank account that has service charge free checking accounts. The Home Manager and Program Director will monitor client accounts at least monthly to ensure there are no service charges applied to the accounts. Responsible Party: Home Manager, Program Director, Are Director</p>		02/26/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401
---	--

(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 G: 7/27/11 - \$12.00, 8/24/11 - \$12.00, 9/27/11 - \$12.00, 10/27/11 - \$12.00, 11/28/11 - \$12.00, and 12/27/11 - \$12.00.</p> <p>-Client H: 7/27/11 - \$12.00, 8/24/11 - \$12.00, 9/27/11 - \$12.00, 10/27/11 - \$12.00, and 11/28/11 - \$12.00.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 1/26/12 at 12:58 PM. AS #1 indicated to address the on-going service charges, the clients were changing banks.</p> <p>An interview with AS #3 was conducted on 1/27/12 at 9:23 AM. AS #3 indicated clients E, F and H had opened new accounts. Clients A, B, C, D and G had not opened new accounts yet. AS #3 indicated the service charges were the fees associated with having a checking account.</p> <p>9-3-2(a)</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W0149	<p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 2 of 2 incidents found while reviewing the clients' financial records affecting clients D, E and F, the facility failed to implement their policy and procedure for conducting thorough investigations.</p> <p>Findings include:</p> <p>1) A review of the clients' finances was conducted on 1/24/12 at 10:36 AM. On 1/20/12, client F had a deposit into his account from client E for the amount of \$85.00 for the repayment of client E stealing client F's cellphone. The entry on the January 2012 Check Register Record indicated, "[client E] paying back [client F] for stealing phone!!"</p> <p>A review of the facility's incident/investigative reports was conducted on 1/23/12 at 1:18 PM. There were no incident or investigative reports for review regarding client F's cellphone being stolen by client E.</p> <p>An interview with the Home Manager (HM) was conducted on 1/27/12 at 9:23 AM. The HM indicated client F initially reported he lost his cellphone but suspected client E took it. The HM</p>	W0149	<p>The Program Director received corrective action and retraining on investigation standards by the Area Director on 12/28/2011. The Program Director will meet with the Area Director weekly to review all incidents and investigations. The Area Director will ensure that all needed investigations are completed for any incidents that require them. All future investigations will be reviewed for completeness and thoroughness by the Area Director and/or Quality Assurance Specialist or other designee. Responsible Party: Home Mangager, Program Director, Area Director.</p>	02/26/2012
-------	---	-------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012
NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>indicated she could not verify this occurred until, months later, she found the cellphone in client E's dresser drawer. Client E denied taking the phone. The HM indicated she did not document her interviews.</p> <p>An interview with Administrative Staff (AS) #3 was conducted on 1/27/12 at 9:23 AM. AS #3 indicated client F reported he had lost his cellphone and never indicated another client took it. A couple of months later, the HM called AS #3 to report she found the cellphone in client E's dresser drawer. The HM called the cellphone provider to verify it was client F's phone; it was client F's phone. Client E indicated he received the phone from a guy from the workshop. When client E was told he would have to reimburse client F for the cellphone, he stated, "Fine, he can have it back then." AS #3 indicated the incident was not investigated.</p> <p>An interview with AS #1 was conducted on 1/26/12 at 12:58 PM. AS #1 indicated the incident should have been investigated.</p> <p>2) A review of the clients' finances was conducted on 1/24/12 at 10:36 AM. On 11/30/11, client D had two withdrawals from his November Check Register</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012	
NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401			
(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>Record, dated November 2011, in the amounts of \$52.00 and \$46.00. The description of purchase section indicated, "Sex Hotline." The paid to section indicated, "See attached." The Account Activity form, dated 12/5/11, highlighted two charges on 11/30/11 for the \$52.00 and \$46.00. A handwritten note to the side of the charges indicated, "Did not have permission to do this; I do not know how he did this!!"</p> <p>A review of the facility's incident/investigative reports was conducted on 1/23/12 at 1:18 PM. There were no incident or investigative reports for review regarding client D's checking account for 11/30/11.</p> <p>An interview with the HM was conducted on 1/27/12 at 9:23 AM. The HM indicated the handwritten note on client D's Account Activity form was written by her. The HM indicated she was still not sure how client D accessed his checking account. The HM indicated client D initially denied making purchases. The HM indicated she told client D she needed to figure out if someone else was accessing his account. He continued to deny making the charges but eventually admitted to calling a sex hotline while visiting his parents. Client D did not tell her how he paid for the two calls. The</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012
NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401		
(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>HM indicated she did not document her interview with client D or the guardian regarding the charges.</p> <p>An interview with AS #3 was conducted on 1/27/12 at 9:23 AM. AS #3 indicated she did not conduct an investigation into client D's charges to his checking account. AS #3 indicated she spoke to client D and client D's guardian. AS #3 indicated she did not document her interviews.</p> <p>A review of the facility's abuse and neglect policy, dated April 2011, was conducted on 1/23/12 at 1:22 PM. The policy indicated the following, "Any allegation of abuse or human rights violation is thoroughly investigated by the Area Director in consultation with Human Resources Department and/or Quality Assurance/Risk Management Department."</p> <p>9-3-2(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012	
NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401			
(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
W0154	<p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 2 of 2 incidents found while reviewing the clients' financial records affecting clients D, E and F, the facility failed to conduct thorough investigations.</p> <p>Findings include:</p> <p>1) A review of the clients' finances was conducted on 1/24/12 at 10:36 AM. On 1/20/12, client F had a deposit into his account from client E for the amount of \$85.00 for the repayment of client E stealing client F's cellphone. The entry on the January 2012 Check Register Record indicated, "[client E] paying back [client F] for stealing phone!!"</p> <p>A review of the facility's incident/investigative reports was conducted on 1/23/12 at 1:18 PM. There were no incident or investigative reports for review regarding client F's cellphone being stolen by client E.</p> <p>An interview with the Home Manager (HM) was conducted on 1/27/12 at 9:23 AM. The HM indicated client F initially reported he lost his cellphone but suspected client E took it. The HM indicated she could not verify this</p>			W0154	<p>The Program Director received corrective action and retraining on investigation standards by the Area Director on 12/28/2012. The Program Director will meet with the Area Director weekly to review all incidents and investigations. The Area Director will ensure that all needed investigations are completed for any incidents that require them. All future investigations will be reviewed for completeness and thoroughness by the Area Director and/or Quality Assurance Specialist or other designee. Responsible Party: Home Mangager, Program Director, Area Director</p>		02/26/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012
NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401		
(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>occurred until, months later, she found the cellphone in client E's dresser drawer. Client E denied taking the phone. The HM indicated she did not document her interviews.</p> <p>An interview with Administrative Staff (AS) #3 was conducted on 1/27/12 at 9:23 AM. AS #3 indicated client F reported he had lost his cellphone and never indicated another client took it. A couple of months later, the HM called AS #3 to report she found the cellphone in client E's dresser drawer. The HM called the cellphone provider to verify it was client F's phone; it was client F's phone. Client E indicated he received the phone from a guy from the workshop. When client E was told he would have to reimburse client F for the cellphone, he stated, "Fine, he can have it back then." AS #3 indicated the incident was not investigated.</p> <p>An interview with AS #1 was conducted on 1/26/12 at 12:58 PM. AS #1 indicated the incident should have been investigated.</p> <p>2) A review of the clients' finances was conducted on 1/24/12 at 10:36 AM. On 11/30/11, client D had two withdrawals from his November Check Register Record, dated November 2011, in the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012	
NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401			
(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>amounts of \$52.00 and \$46.00. The description of purchase section indicated, "Sex Hotline." The paid to section indicated, "See attached." The Account Activity form, dated 12/5/11, highlighted two charges on 11/30/11 for the \$52.00 and \$46.00. A handwritten note to the side of the charges indicated, "Did not have permission to do this; I do not know how he did this!!"</p> <p>A review of the facility's incident/investigative reports was conducted on 1/23/12 at 1:18 PM. There were no incident or investigative reports for review regarding client D's checking account for 11/30/11.</p> <p>An interview with the HM was conducted on 1/27/12 at 9:23 AM. The HM indicated the handwritten note on client D's Account Activity form was written by her. The HM indicated she was still not sure how client D accessed his checking account. The HM indicated client D initially denied making purchases. The HM indicated she told client D she needed to figure out if someone else was accessing his account. He continued to deny making the charges but eventually admitted to calling a sex hotline while visiting his parents. Client D did not tell her how he paid for the two calls. The HM indicated she did not document her</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401
---	--

(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>interview with client D or the guardian regarding the charges.</p> <p>An interview with AS #3 was conducted on 1/27/12 at 9:23 AM. AS #3 indicated she did not conduct an investigation into client D's charges to his checking account. AS #3 indicated she spoke to client D and client D's guardian. AS #3 indicated she did not document her interviews.</p> <p>9-3-2(a)</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012
NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401		
(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	
W0227	<p>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on observation, record review and interview for 3 of 4 clients in the sample (D, E and F), the facility failed to ensure:</p> <p>1) there was a plan for client F's independent time in the community, 2) client F had a plan for bus training, 3) client E had a plan for materials checked out from the library, and 4) recommendations by client D's dentist were implemented.</p> <p>Findings include:</p> <p>1) An observation was conducted at the group home on 1/23/12 from 3:54 PM to 5:28 PM. At 4:54 PM, client F indicated to Administrative staff (AS) #1 he liked his 3 hour alone time in the community.</p> <p>A review of client F's record was conducted on 1/24/12 at 11:33 AM. Client F's Individual Support Plan (ISP), dated 8/17/11, did not indicate client F had alone time in the community. The ISP indicated, "Assessment of his/her supervision needs: Requires 24 hour supervision." The record did not contain an addendum to the ISP or an team meeting record determining client F could have alone time. The record did not</p>	W0227	<p>The Program Director was retrained on updating client's plans based on recommendations obtained from the client's team, including doctors, therapists, and other supporting parties on 1/27/2012. Client F's Individual Support Plan has been updated to include his plan for independent time in the community and bus training. Client E's Individual Support Plan has been updated to include his plan for materials checked out from the library. Client D's Individual Support Plan has been updated to include his recommendations from his dentist. Staff in the home were trained on these updated plans on 1/3/2012 and 2/20/2012. The Home Manager and Program Director will complete weekly observations and reviews to ensure these updated plans are being followed. Responsible Party: Home Manager, Program Director, Area Director</p>	02/26/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012	
NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401			
(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>include a plan for the client F's independent time in the community.</p> <p>An interview with the Home Manager (HM) was conducted on 1/27/12 at 9:23 AM. The HM indicated there was no plan for the staff to implement in regard to client F's independent time in the community.</p> <p>An interview with Administrative staff (AS) #3 was conducted on 1/27/12 at 9:23 AM. AS #3 indicated she was supposed to add a plan to client F's ISP but did not. AS #3 indicated there needed to be a plan for client F's independent time in the community.</p> <p>An interview with AS #1 was conducted on 1/26/12 at 12:58 PM. AS #1 indicated there was no plan in place. AS #1 indicated client F's ISP should include a plan for the independent time in the community.</p> <p>2) A review of client F's record was conducted on 1/24/12 at 11:33 AM. A Medical Appointment Form, dated 11/10/11, for his counselor indicated the following, "Worked on dispelling mistaken beliefs and fears of bus transport. Goal: to take bus to mall, downtown and [name of recreation center]." A review of client F's ISP, dated</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012	
NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401			
(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>8/17/11, indicated there was no plan for public transportation training.</p> <p>An interview with AS #1 was conducted on 1/26/12 at 12:58 PM. AS #1 indicated there was no plan in place for bus training.</p> <p>3) A review of client E's financial records was conducted on 1/24/12 at 10:36 AM. On 9/1/11 client E paid the public library \$129.17. The Description of Purchase indicated "paying bill." On 11/14/11 client E paid the public library \$43.08. The Description of Purchase indicated "paying off bill." A review of the bill, dated 1/26/12, indicated client E's fees were related to overdue items, damaged item, replacement costs for items and collection agency costs.</p> <p>A review of client E's record was conducted on 1/24/12 at 11:13 AM. There was no documentation in his record indicating there was a plan for items borrowed from the library.</p> <p>An interview with AS #1 was conducted on 1/26/12 at 12:58 PM. AS #1 indicated client E's repayment to the library addressed overdue fees and replacement costs for compact discs he sold to other clients. AS #1 indicated there was no plan addressing client E's borrowing items</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012	
NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401			
(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>from the library.</p> <p>An interview with the HM was conducted on 1/27/12 at 9:23 AM. The HM indicated client E would get the bills from the library and throw them away before staff could see the bills. The HM indicated she found out client E owed money to the library while searching his dresser drawers. The HM indicated there was no plan in place addressing items borrowed from the library.</p> <p>4) A review of client D's record was conducted on 1/24/12 at 11:09 AM. On 11/23/11, client D was seen by his dentist. The recommendations included brushing 2-3 times per day for 2 minutes. Client D's January 2012 medication administration record indicated the staff were to prompt client D to brush twice a day (morning and evening). There was no documentation for staff to prompt 2-3 times per day for 2 minutes.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 1/26/12 at 12:58 PM. AS #1 indicated there should be a training objective addressing the dentist's recommendations for 2-3 times per day for 2 minutes.</p> <p>9-3-4(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2012	
NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401			
(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
W0248	<p>A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on record review and interview for 2 of 2 clients (B and H) who attended workshop #1, the facility failed to ensure the workshop had the clients' current plans to implement.</p> <p>Findings include:</p> <p>A review of the client B's record at workshop #1 was conducted on 1/23/12 at 3:07 PM. Client B's Individual Support Plan (ISP) was dated 7/28/10. A review of client H's record at workshop #1 was conducted on 1/23/12 at 3:09 PM. Client H's ISP was dated 7/7/10.</p> <p>A review of client B's record at the group home was conducted on 1/24/12 at 10:59 AM. Client B's current ISP was dated 10/12/11.</p> <p>A review of client H's record at the group home was conducted on 1/24/12 at 10:45 AM. Client H's current ISP was dated 9/1/11.</p> <p>An interview with the Home Manager (HM) was conducted on 1/23/12 at 4:04 PM. The HM indicated she did not ensure workshop #1 had client B and H's</p>			W0248	<p>All current Individual Support Plans were sent by the Program Director, to the appropriate day program to ensure they have copies for their files or personal records on 1/23/2012. The Program Director will ensure a copy of each ISP is received by the appropriate parties after the completion of the program plan according to stated guidelines. Responsible Party: Program Director and Area Director.</p>		02/26/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401
---	--

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

	current plans. The HM indicated the workshop needed to have client B and H's current plans to implement the plans.  9-3-4(a)			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/27/2012	
NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401			
(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>The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on record review and interview for 2 of 4 clients in the sample (B and G), the facility's nursing services failed to ensure follow-up appointments occurred.</p> <p>Findings include:</p> <p>A review of client B's record was conducted on 1/26/12 at 1:32 PM. Client B was seen by the podiatrist on 10/27/11. A follow-up appointment was scheduled for 1/17/12. There was no documentation in client B's record indicating the 1/17/12 appointment occurred. There was no documentation a follow-up appointment with the podiatrist was held on another date.</p> <p>A review of client G's record was conducted on 1/26/12 at 1:59 PM. Client G was seen by his eye doctor on 1/14/11. The results indicated client G was legally blind and had cataracts. The form indicated a 1 year follow-up. There was no documentation in client G returned to the eye doctor in 2011 or 2012.</p> <p>An email from Administrative staff (AS) #1 was received and reviewed on 1/26/12 at 2:56 PM. AS #1 indicated client B had a follow-up appointment scheduled on 2/20/12 and client G had a follow-up</p>			W0331	<p>The staff responsible who failed to complete follow up appointments for Client B and Client G were given Corrective Actions. Staff in the home were retrained on 1/31/2012 and 2/20/2012 on completing all scheduled appointments for all clients. Client B had his follow up appointment on 2/20/2012 and Client G had his follow up appointment on 2/2/2012. The Home Manager and Program Director will monitor that appointments are completed as schedule clients' health and safety. Responsible Party: Home Manager, Program Director, and Area Director.</p>		02/26/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401
---	--

(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>appointment scheduled on 2/2/12.</p> <p>An interview with the Home Manager (HM) was conducted on 1/27/12 at 9:23 AM. The HM indicated the clients had appointments scheduled but missed the appointments. The HM indicated the appointments were rescheduled on 1/26/12.</p> <p>An interview with AS #3 was conducted on 1/27/12 at 9:23 AM. AS #3 indicated the follow-up appointments were rescheduled on 1/26/12.</p> <p>An interview with the nurse was conducted on 1/27/12 at 11:57 AM. The nurse indicated follow-up appointments should have been completed. The nurse stated, "there's no way around it, they should have been done."</p> <p>9-3-6(a)</p>			
--	---	--	--	--