

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460
---	---

(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
W000000	<p>This visit was for the post certification revisit (PCR) to the annual recertification and licensure survey completed on 11/22/13.</p> <p>Survey Dates: February 3 and 4, 2014</p> <p>Facility Number: 000824 Provider Number: 15G305 AIM Number: 100249060</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/7/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS 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>	W000125	Phone contact with legal agency was made on 2/10/2014 and 2/19/2014 messages were left on	03/06/2014

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: 15G305		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/04/2014	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460			
(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>Based on record review and interview for 3 of 4 clients in the sample (#1, #2 and #3), the facility failed to ensure the clients' rights by not obtaining a legally sanctioned decision maker to assist in medical and financial decisions.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 2/3/14 from 4:19 PM to 5:42 PM. During the observation, clients #1 and #3 did not communicate using words, signs or communication devices.</p> <p>A review of the facility's Plan of Correction (POC), dated 12/17/13, was conducted on 2/3/14 at 11:57 AM. The POC indicated, in part, "The teams will meet for each client to assess the need for guardianship or a health care representative. An attorney will be contacted to facilitate this process. ADDENDUM: All teams for clients without guardians or legally sanctioned representatives, will meet to determine the need for a legally sanctioned decision maker to assist in medical and</p>		<p>2/27/2014 letter was sent to legal agency. If contact isn't made from this legal agency within two weeks another legal agency will be contacted. Responsible Party: Program Director</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/04/2014
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460		
(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>financial decisions. An attorney will be contacted to help facilitate this process after IDT's are completed. At least annually, each client's (sic) team will meet to discuss the need for a legally sanctioned decision maker."</p> <p>A review of an IDT (interdisciplinary team) note, dated 11/22/13, was conducted on 2/3/14 at 1:43 PM. The note indicated, in part, "Team discussed guardianship and health care representation (HCR) for [client #3]. Team agreed [client #3] would benefit from full guardianship. Team discussed guardianship and health care representation for [client #1]. Team agreed [client #1] would benefit from full guardianship. Team discussed guardianship and health care representation for [client #2]. Team agreed [client #2] would benefit from having a health care representative."</p> <p>A review of client #1's record was conducted on 2/3/14 at 5:29 PM. Client #1's Individual Support Plan (ISP), dated 5/23/13, indicated, "Legal status: Emancipated." A review of his Risk Management Assessment and Plan (RMAP), dated 5/23/13, indicated, "Guardianship Status: Self. Financial: Presents a risk. Cannot manage his own money. TSI/Mentor is representative</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/04/2014	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460			
(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>payee for Social Security benefits. [Client #1's] petty cash account is reconciled at least one monthly. His savings account is reconciled monthly. Unable to recognize mismanagement (finances). Unable to report mismanagement of finances." There was no documentation in client #1's record indicating action had been taken to secure a guardian.</p> <p>A review of client #2's record was conducted on 2/3/14 at 5:30 PM. Client #2's ISP, dated 6/13/13, indicated, "Legal Status: Emancipated Adult. A review of his RMAP, dated 6/13/13, indicated, "Guardianship Status: Self. Financial: Presents a risk. Needs assistance with finances. TSI/Mentor is representative payee for [client #2's] Social Security benefits. Unable to recognize mismanagement (finances). Unable to report mismanagement of finances." There was no documentation in client #2's record indicating action had been taken to secure a health care representative.</p> <p>A review of client #3's record was conducted on 2/3/14 at 5:33 PM. Client #3's ISP, dated 7/17/13, indicated, "Legal Status: Emancipated." The ISP indicated, "Unable to communicate verbally." A review of his RMAP, dated</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/04/2014	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460			
(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>7/17/13, indicated, "Guardianship Status: self. Financial: presents a risk. Unable to recognize mismanagement. Unable to report mismanagement of finances. TSI/Mentor is representative payee for Social Security benefits." There was no documentation in client #3's record indicating action had been taken to obtain to secure a guardian.</p> <p>On 2/3/14 at 12:46 PM, the Area Director (AD) indicated an attorney had not conducted her assessment. The AD indicated an attorney would assess the clients to see if they needed a health care representative or guardian. The AD indicated he was not sure if the Program Director (PD) convened the clients' IDTs to discuss HCR and guardianship.</p> <p>On 2/3/14 at 12:53 PM, the PD indicated the IDT met to discuss health care representation and guardianship for clients #1, #2 and #3. The PD indicated the IDT determined clients #1 and #3 needed guardianship and client #2 needed a health care representative since client #2 was able to communicate verbally. The PD indicated she had not contacted the attorney to set up a time for the attorney to assess the needs of clients #1, #2 and #3.</p> <p>This deficiency was cited on 11/22/13.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/04/2014	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460			
(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			
W000140	<p>The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p> <p>483.420(b)(1)(i) CLIENT FINANCES 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 5 of 7 clients living in the group home (#2, #5, #6, #7 and #8), the facility failed to keep a full and complete accounting of the clients' personal funds.</p> <p>Findings include:</p> <p>On 2/3/14 at 3:41 PM, a review of the clients' finances was conducted and indicated the following:</p> <p>-Client #2's Cash on Hand ledger, dated February 2014, indicated he had \$62.91 in his account. When the Program</p>	W000140	<p>Corrective action was done with the Home Manager on 2/5/2014. Program Director will check finances weekly to ensure that there are no discrepancy in client finances. Responsible Party: Program Director</p>	03/06/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460
---	---

(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>Director (PD) counted client #2's cash on hand, he had \$62.06. There was no documentation explaining the discrepancy between the ledger balance and the cash on hand.</p> <p>-Client #5's Cash on Hand ledger, dated February 2014, indicated he had \$39.65 in his account. When the PD counted client #5's cash on hand, he had \$39.66. There was no documentation explaining the discrepancy between the ledger balance and the cash on hand.</p> <p>-Client #6's Cash on Hand ledger, dated February 2014, indicated he had \$54.64 in his account. When the PD counted client #6's cash on hand, he had \$54.49. There was no documentation explaining the discrepancy between the ledger balance and the cash on hand.</p> <p>-Client #7's Cash on Hand ledger, dated February 2014, indicated he had \$171.42 in his account. When the PD counted client #7's cash on hand, he had \$171.18. There was no documentation explaining the discrepancy between the ledger balance and the cash on hand.</p> <p>-Client #8's Cash on Hand ledger, dated February 2014, indicated he had \$320.14 in his account. When the PD counted client #8's cash on hand, he had \$290.00.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460
---	---

(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
W000203	<p>There was no documentation explaining the discrepancy between the ledger balance and the cash on hand.</p> <p>On 2/3/14 at 4:11 PM, the PD indicated the facility should account for the clients' finances to the penny. The PD indicated the facility needed to account for all withdrawals and deposits on the Cash on Hand ledger for each transaction.</p> <p>This deficiency was cited on 11/22/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p> <p>483.440(b)(5)(i) ADMISSIONS, TRANSFERS, DISCHARGE At the time of the discharge the facility must develop a final summary of the client's developmental, behavioral, social, health and nutritional status.</p> <p>Based on record review and interview for 1 of 1 client (#4) who was discharged from the group home since the annual recertification and state licensure survey completed on 11/22/13, the facility failed to develop a final summary of the client's developmental, behavioral, social, health and nutritional</p>	W000203	<p>Discharge summary was completed on 2/5/2014. Retraining of Program Director was completed on 2/5/14. Responsible Party: Program Director</p>	03/06/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/04/2014	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460			
(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			
W000248	<p>status.</p> <p>Findings include:</p> <p>A review of client #4's record was conducted on 2/4/14 at 10:13 AM. Client #4 was discharged from the facility on 1/13/14 to another group home managed by the facility. The facility did not provide documentation indicating a final summary of client #4's developmental, behavioral, social, health and nutritional status was developed at the time of discharge on 1/13/14.</p> <p>On 2/3/14 at 12:53 PM, the Program Director (PD) indicated there was no discharge summary completed for client #4. The PD stated, "I was responsible and one should have been completed." The PD indicated client #4 transferred to another TSI group home on 1/13/14.</p> <p>9-3-4(a)</p> <p>483.440(c)(7) INDIVIDUAL PROGRAM PLAN 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. Based on record review and interview for 1 of 1 client (#8) who moved into the</p>	W000248	Home Manager and staff training was completed on 2/7/2014 for	03/06/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/04/2014	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460			
(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>facility since the annual recertification and state licensure survey was completed on 11/22/13 and one additional client (#7), the facility failed to ensure client #7 and #8's Individual Support Plans (ISP) were available at the group home for all relevant staff.</p> <p>Findings include:</p> <p>On 2/3/14 at 5:29 PM, a review of client #7's record was conducted. Client #7's program binder included an ISP dated 11/9/12. On 2/4/14 at 10:53 AM, the facility emailed client #7's current ISP, dated 11/1/13. Client #7's 11/1/13 ISP was not at the group home for all relevant staff to review.</p> <p>On 2/3/14 at 5:29 PM, a review of client #8's record was attempted while at the group home. Client #8 did not have a program binder at the home for review. Client #8's current ISP, dated 11/22/13, was not at the group home for review.</p> <p>On 2/3/14 at 5:29 PM, the Program Director (PD) indicated client #8's program binder, which included his ISP, was being put together at the facility office. The PD indicated client #8's current ISP was not in the home for all relevant staff to review. The PD indicated she was not sure why client</p>		<p>what client documents are to be kept in the home. Program Director will check client documents in the home at least monthly to ensure proper documents are in place. Responsible Party: Program Director</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460
---	---

(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
W000250	<p>#7's current ISP was not in client #7's program binder. The PD indicated the clients' current program plans should be available for review to all relevant staff at the group home.</p> <p>9-3-4(a)</p> <p>483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.</p> <p>Based on record review and interview for 7 of 7 clients living in the group home (#1, #2, #3, #5, #6, #7 and #8), the facility failed to develop individualized active treatment schedules for the clients.</p> <p>Findings include:</p>	W000250	<p>Program Director revised/updated active treatment schedules on 2/10/2014. Client Active Treatment schedules will be revised and updated annually or if any client schedule changes occur. Area Director will review with Program Director at least monthly to ensure active treatment schedules are being completed at least annually or when changes occur for the clients in the home. Responsible Party: Area Director and Program Director</p>	03/06/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460
---	---

(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 review of the facility's Plan of Correction (POC), dated 12/17/13, was reviewed on 2/3/14 at 11:57 AM. The POC indicated, in part, "All clients (sic) Active Treatment Schedules will be reviewed and revised as needed to make sure they are individualized and include meaningful activity."</p> <p>A review of the clients' Active Treatment Schedules (ATS) was conducted on 2/3/14 at 4:26 PM. Clients #1, #2 and #3's ATS were dated 5/1/13. Client #5's ATS was dated 4/5/12. Client #6's ATS was dated April 2012. Clients #7 and #8 did not have active treatment schedules. Clients #5 and #6's ATS were identical. Clients #1, #2 and #3's ATS were identical. The facility did not provide documentation indicating the clients' ATS were reviewed and revised since the annual recertification and state licensure survey completed on 11/22/13.</p> <p>On 2/3/14 at 4:18 PM, the Program Director (PD) indicated the clients' ATS had not been revised or updated since the annual recertification survey. The PD indicated she was unaware the ATS needed to be revised or updated.</p> <p>This deficiency was cited on 11/22/13.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/04/2014
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460		
(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	
	The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-4(a)				