STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 12/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL SERVICES SUB LLC	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
K010000	A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 12/04/13 Facility Number: 000824 Provider Number: 15G305 AIM Number: 100249060 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Transitional Services Sub, LLC. was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This two story facility with a basement was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in corridors, in sleeping rooms, in common living areas and on all levels. The facility has the capacity for 8 and had a census of 8 at the time of this survey.	K010000		

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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	Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 1.2. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/10/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K01S147	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD The administration of every resident board and care facility has in effect and available to all supervisory personnel written copies of a plan for protecting of all persons in the event of fire, for keeping persons in place, for evacuating persons to areas of refuge, and for evacuating persons from the building when necessary. The plan includes special staff response, including fire protection procedures needed to ensure the safety of any resident, and is amended or revised whenever any resident with unusual needs is admitted to the home. All employees are periodically instructed and kept informed with respect to their duties and responsibilities under the plan. Such instruction is reviewed by the staff not less than every 2 months. A copy of the plan is readily available at all times within the facility. 32.7.1, 33.7.1 Based on record review and interview, the facility administration failed to ensure all employees are periodically instructed and kept informed with respect to their duties and responsibilities under the plan for special staff response, including fire protection procedures needed to ensure the safety of 8 of 8 clients, which is amended or revised whenever any resident with unusual needs is admitted to the home. Such instruction is reviewed by the staff at least every two months. This deficient practice could affect all clients. Findings include:	K01S147	Staff training completed on 12/18/2013 on monthly fire drills and monthly fire drill schedules and evacuation plans. Training was completed on fire safety watch including 15 minute checks and documentation of fire safety watch. Responsible Party: Area Director, Program Director will monitor monthly.	01/03/2014

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	Based on Fire Drill Reports reviewed with the house staff on 12/04/13 at 1:05 p.m., a lapse in staff fire safety training time was more than the two months allowed as evidenced by the lack of any record of a third shift fire drill between 10/01/12 and 05/25/13, a period of seven months. A lapse of six months between fire drills for the third shift occurred when there was no documentation between 06/08/13 and 12/04/13. The second shift drills missing between 10/01/12 and 05/24/13 evidenced a lapse of seven months between drills. The house staff said at the time of record review, she thought all the drills were done but could not find them. Calls to the main office for delivering missing documentation via fax failed to supply the missing drills or any other evidence of fire safety staff training.			

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K01S152	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD (1) The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to - (i) Ensure that all personnel on all shifts are trained to perform assigned tasks; (ii) Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. (2) The facility must - (i) Actually evacuate clients during at least one drill each year on each shift; (ii) Make special provisions for the evacuation of clients with physical disabilities: (iii) File a report and evaluation on each drill: (iv) Investigate all problems with evacuation drills, including accidents and take corrective action: and (v) During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code. (3) Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. Based on record review and interview, the facility failed to ensure fire and evacuation drills were provided for each shift for 3 of 4 quarters. This deficient practice affects all occupants. Findings include: Based on Fire Drill Reports reviewed with the house staff on 12/04/13 at 1:05	K01S152	Staff training completed on 12/18/2013 on monthly fire drills and monthly fire drill schedules and evacuation plans. Training was completed on fire safety watch including 15 minute checks and documentation of fire safety watch. Responsible Party: Area Director, Program Director will monitor bi monthly	01/03/2014

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	p.m., fire drill records were not provided between 10/01/12 and 05/25/13, and 06/08/13 to 12/04/13 for the third shift; and between 10/04/12 and 05/24/13 for the second shift. The house staff said at the time of record review, she thought all the drills were done but could not find them. Calls to the main office for delivering missing documentation via fax failed to supply the missing drills.			