

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G435	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4155 RAY ST INDIANAPOLIS, IN 46241
---	--

(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	<p>A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 04/24/13</p> <p>Facility Number: 000949 Provider Number: 15G435 AIM Number: 100244680</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist,</p> <p>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.</p> <p>This one story building was determined to be fully sprinklered. The facility has a fire alarm system with smoke detection in corridors, sleeping rooms and all living areas. The facility has a capacity of 8 and had a census of 6 at the time of this survey.</p>	K010000		

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: 15G435	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4155 RAY ST INDIANAPOLIS, IN 46241
---	--

(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>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Slow with an E-Score of 2.6.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/25/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G435		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 04/24/2013	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 4155 RAY ST INDIANAPOLIS, IN 46241			
(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			
K010130	<p>Based on observation and interview, the facility failed to ensure 1 of 2 portable fire extinguishers located in the facility was inspected at least monthly and the inspections were documented including the date and initials of the person performing the inspection. LSC 4.6, General Requirements at 4.6.12.2 requires existing LSC features obvious to the public, such as fire extinguishers, to be either maintained or removed. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.4.2 requires at least monthly, the date of inspection and the initials of the person performing the inspection shall be recorded. In addition NFPA 10, 4-2.1 defines inspection as a quick check an extinguisher is available and will operate. This deficient practice could affect all clients, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Home Manager during a tour of the facility from 11:25 a.m. to 11:50 a.m. on 04/24/13, the portable fire extinguisher located in the kitchen had an affixed inspection and maintenance tag lacking a monthly inspection for March 2013. Based on interview at the time of observation, the Home Manager stated no other</p>	K010130	<p>Program Director will retrain Home Manager on completing monthly home inspections, to include, checking fire extinguishers for monthly and annual checks, replacing any missing inspection stickers and notifying administration when an annual inspection has not been completed by US automatic. Home Manager will retrain staff on inspecting fire extinguishers monthly during routine evacuation drills. Program Director will inspect extinguishers during routine bi-weekly home inspections to ensure they have been inspected and signed off per regulation. Responsible Parties: Home Manager, Program Director</p>	05/24/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G435	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4155 RAY ST INDIANAPOLIS, IN 46241
---	--

(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
	documentation of monthly fire extinguisher inspections was available for review and acknowledged a monthly inspection of the aforementioned portable fire extinguisher had not been documented for March 2013.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G435		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 04/24/2013	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 4155 RAY ST INDIANAPOLIS, IN 46241			
(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			
K01S152	<p>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.</p> <p>(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.</p> <p>(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 conduct fire drills under varied conditions for 4 of 4 third shift fire drills. This deficient practice affects all clients and staff.</p> <p>Findings include: Based on review of "Fire Drill/Fire Report" documentation with the Area</p>	K01S152	<p>The Evacuation drill schedule for 2013 was written so that drills each month are scheduled in varied time frames throughout the year.</p> <p>The Program Director will retrain the Home Manager on ensuring evacuation drills are completed during the time specified on the 2013 schedule.</p>	05/24/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G435	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 04/24/2013
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 4155 RAY ST INDIANAPOLIS, IN 46241		
(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	
	Director during record review at the Corporate Office from 10:15 a.m. to 10:50 a.m. on 04/24/13, third shift fire drills conducted on 06/09/12, 09/09/12, 12/08/12 and 03/09/13 were conducted at, respectively, 1:30 a.m., 1:30 a.m., 1:30 a.m. and 2:00 a.m. Based on interview at the time of record review, the Area Director acknowledged third shift fire drills were not conducted under varied conditions.		The Home Manager will retrain staff on completing evacuation drills during the time frame specified in the 2013 drill schedule. The monthly evacuation drills are submitted to the Quality Assurance Specialist monthly to ensure that drills are completed accurately and during the specified drill time. Responsible party: Program Director, Home Manager, Quality Assurance Specialist		