

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G300	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/02/2012
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151		
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W0000	<p>This visit was for a recertification and state licensure survey.</p> <p>Survey Dates: June 26, 27, 28, 29 and July 2, 2012.</p> <p>Facility Number: 000819 Provider Number: 15G300 AIM Number: 100249100</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 7/11/12 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.

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W0120	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client.</p> <p>Based on observation, interview and record review for 2 of 2 clients who attended an outside services workshop (#1 and #2), the facility failed to ensure the outside services met the needs of the clients in regard to workshop staff training, clients' plans being accessible to the workshop staff and daily communication between the workshop and the group home.</p> <p>Findings include:</p> <p>An observation was conducted on 6/27/12 from 6:05 AM to 8:04 AM at the group home. At 6:33 AM, client #1 became upset. Client #1 indicated a peer at the workshop kept staring at him. Direct care staff (DCS) #5 asked client #1 what he should do when he became upset. Client #1 stated he should "calm down." DCS #5 prompted client #1 to take a deep breath and he did. Client #1 indicated he was calm. DCS #5 prompted client #1 to change his shirt (same shirt he wore during the evening observation on 6/26/12) and shave his whiskers. Client #1 indicated he was getting upset and did not want to change his shirt. DCS #1 prompted client #1 when he finished his</p>	W0120	<p>TSI is committed to ensuring outside services meet the needs of each client. The workshop staff for clients 1 and 2 have been trained on clients plans. A plan has been developed between this workshop and TSI to ensure all staff working with these clients are trained on their plans on an ongoing basis. This plan includes ensuring that substitute staff are also trained prior to working with these clients. The Program Director and Home Manager complete at least monthly observations and have been trained to check with day services staff to ensure all current client plans are available and accessible to all day services staff that work with the clients. Management staff will ensure that clients plans are current and updated as plans change. Communication books have been initiated for all clients and their respective day services to ensure daily communication. Staff in the home were trained on 7/2/2012 and 7/19/2012 on how to manage communication books for all clients in the home. Day Program staff were trained on 7/19/2012 on the use of communication book daily. These communication books are monitored by management staff</p>	08/01/2012			

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	<p>meds he was going to remain calm, "make the wind blow," and have a good day. At 6:38 AM, DCS #5 indicated she needed to inform the other staff working at the home not to prompt client #1 anymore regarding changing his shirt and shaving. DCS #1 indicated if client #1 was prompted more than three times, he may become physically aggressive.</p> <p>An observation was conducted at the workshop clients #1 and #2 attended on 6/27/12 from 9:37 AM to 10:49 AM. At 9:48 AM, client #2 was sleeping at his workstation. Workshop supervisor #1 woke client #2 and he worked the remainder of the observation. Client #1 was out of the work area upon arrival. Client #1 returned to the work area at 9:50 AM from a walk. Client #1 alternated between working and walking around the room.</p> <p>A review of client #1's record was conducted on 6/28/12 at 11:42 AM. Client #1's Individual Support Plan (ISP) was dated 4/13/12. His Behavior Development Program (BDP) was dated 2/9/12.</p> <p>A review of client #2's record was conducted on 6/28/12 at 12:11 PM. Client #2's ISP was dated 2/22/12. Client #2's ISP indicated, "[client #2] does NOT</p>		<p>at least weekly to ensure they are used daily by staff and day servcies.Management staff have been trained on how to document weekly monitoring of these communication books.Responsible Party: Program Director, Area Director, and Quality Assurance Specialist</p>				

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	<p>have Behavior Support Services."</p> <p>An interview with workshop supervisor (WS) #1 was conducted on 6/27/12 at 9:48 AM. WS #1 indicated client #1 had been yelling at WS (substitute staff) #2 prior to the surveyor's arrival to the workshop. WS #1 indicated she was not informed client #1 had been agitated at the group home on the morning of 6/27/12 but this information would have been good to know. WS #1 indicated the production area clients #1 and #2 worked had many substitute staff working in the area. WS #1 indicated there was no communication book between the group home and the workshop.</p> <p>A review of clients #1 and #2's plans at the workshop was conducted on 6/27/12 at 10:12 AM. The plans available to the workshop staff located in a binder in the workshop administrator #1's (WA) office were not the current plans. Client #1 and #2's Individual Support Plans were dated 2011. Client #1's Behavior Development Plan (BDP) was also dated 2011. WA #1 indicated the Program Director (PD) from the group home had sent her the current plans however she was unable to locate them initially. The WA printed off the plans from her email on her computer. The WA, on 6/27/12 at 10:14 AM, indicated she was unable to locate</p>						

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	<p>training documentation for the staff working in the workshop. She stated the staff were "always" in training and the substitute staff were "always" with a familiar, trained staff.</p> <p>An interview with WA #2 was conducted on 6/27/12 at 10:23 AM. WA #2 indicated the workshop did not have a written procedure in place for training staff.</p> <p>An interview with the workshop's Human Resources (HR) staff #1 was conducted on 6/27/12 at 10:38 AM. HR #1 indicated there was no written policy/procedure in place for the workshop staff to be trained on the clients' plans. HR #1 indicated the system currently in place did not work. HR #1 indicated she had never seen staff training documentation for the workshop staff. HR #1 indicated she was told the workshop had their own binders for training documentation and the information was not submitted to HR. HR #1 indicated HR should have the training documentation. HR #1 indicated each workshop staff's employee file should have training documentation on client-specific training.</p> <p>An interview with the workshop's HR staff #2 was conducted on 6/27/12 at</p>				

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	<p>10:49 AM. HR #2 indicated she was unable to locate documentation the staff (both regular staff and substitute) received training on client #1 and #2's program plans.</p> <p>An interview with Quality Assurance (QA) staff for the group home was conducted on 6/27/12 at 12:59 PM. The QA staff indicated there should be a communication book between the group home and the workshop. The QA staff indicated the Program Director (PD) for the group home should train the supervisor of the workshop and then the supervisor would then train the workshop staff.</p> <p>An interview with the Program Director (PD) for the group home was conducted on 6/27/12 at 1:00 PM. The PD indicated a communication book would be a good way for the staff at the workshop and group home to communicate. The PD indicated the PD and home manager should provide training to the administrator at the workshop at then the administrator should train the workshop staff. The PD indicated if the workshop did not provide training then the group home staff should provide the training to the workshop staff. The PD indicated she had not provided training to the administrator of the workshop or the staff</p>				

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	<p>at the workshop. The PD indicated the clients' plans should be accessible to the workshop staff.</p> <p>An interview with the Area Director (AD) was conducted on 6/29/12 at 12:21 PM. The AD indicated communication books between the workshop and the group home should be in place. The AD indicated the group home staff need to ensure the workshop staff received training on the clients' plans. The AD indicated the clients' plans should be accessible to the workshop staff.</p> <p>9-3-1(a)</p>				

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W0124	<p>483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.</p> <p>Based on interview and record review for 1 of 4 clients in the sample (#7), the facility failed to ensure the client's guardian was notified of physician's appointments.</p> <p>Findings include:</p> <p>A review of client #7's record was conducted on 6/28/12 at 12:39 PM. Client #7's record did not contain documentation indicating the facility was notifying the guardian of upcoming physician's appointments.</p> <p>An interview with client #7's guardian was conducted on 6/28/12 at 3:15 PM. The guardian indicated she was not being notified of client #7's physician's appointments and she wanted to be notified. The guardian indicated she used to be notified of all physician's appointments.</p> <p>An interview with the Home Manager (HM) was conducted on 6/29/12 at 12:21</p>	W0124	<p>Client 7's guardian was contacted with a calendar of information she would like to receive on an on-going basis in regards to client 7's medical appointments. The Home Manager was trained on 7/18/2012 on ensuring client's guardian's receive notification of requested information such as doctors appointments. Guardians for clients in the home were contacted to determine what information they would like to receive for their client on an on-going basis. This information has been documented on each clients ISP. The Home Manager was trained on 7/18/2012 to document dates of contact with each guardian regarding the information they request each month on the Home Manager Monthly Report. Responsible Party: Program Director, Area Director, and Quality Assurance Specialist</p>	08/01/2012			

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	<p>PM. The HM indicated she was responsible for notifying the guardian of the physician's appointments. The HM indicated she had notified client #7's guardian in the past however she stopped notifying the guardian. The HM indicated she needed to notify the guardian of upcoming appointments.</p> <p>9-3-2(a)</p>				

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W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on record review and interview for 11 of 43 incident/investigative reports reviewed affecting 7 of 7 clients living in the group home (#1, #2, #3, #4, #5, #6 and #7) and one additional client who moved out (#8), the facility failed to implement its policies and procedures to prevent abuse and neglect of the clients.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 6/26/12 at 2:43 PM and 6/28/12 at 9:42 AM.</p> <p>-On 12/31/11 at 6:00 PM, client #1 hit client #6 in the face repeatedly after client #6 would not stop kicking the seat and door of the van. Client #6 hit client #1 back in the face. Client #1 reported client #6 bent his glasses. Client #6 indicated client #1 broke his glasses. Client #5 indicated both clients #1 and #6 hit each other. Client #6 had red marks on his "upper body" and face and client #1 had a "bite mark" on his leg with no broken skin.</p> <p>-On 2/27/12 at 6:10 PM, clients #4 and #2</p>	W0149	<p>The Program Director was retrained on 7/23/2012 on completing IDT's for clients after incidents if there is evidence to support client to client abuse to ensure client safety and work toward prevention of future incidents. All future investigations will be reviewed by the Area Director and if evidence is found to support that client to client abuse occurred, will work with the Program Director to ensure meetings are completed and program plans are changed as needed to ensure client. The Program Director will update client's plans as needed after incidents and train staff on any program plan changes. Health and Safety Assessments are completed quarterly where each client has an opportunity to review their satisfaction with things in their home, including how they feel about their safety in the home. These assessments are reviewed by the Area Director and the Quality Assurance Specialist. Responsible Party: Program Director, Area Director, and Quality Assurance Specialist</p>	08/01/2012			

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	<p>were returning from church dinner and sitting near each other in the van. Client #4 grabbed client #2's shirt and attempted to rip it off. Client #2 had two small red scratch marks on his shoulder with no broken skin.</p> <p>-On 4/16/12 at 1:45 PM at an outside services workshop, client #5's peer was "mocking" him. Client #5 then pushed his peer. The peer was not injured.</p> <p>-On 4/17/12 at 7:00 AM, client #1 hit client #8 (a former client living in the group home) on the top of his head with an open hand after client #8 had grabbed client #1's lunch box. No injury. The investigative report indicated, "There is evidence to support that [client #1] had hit [client #8] with an open hand on the top of [client #8's] head."</p> <p>-On 4/22/12 at 10:00 PM, client #4 lunged onto the floor and grabbed client #7's bare feet (the report indicated client #7 was prompted several times to keep his shoes and socks on however he refused). Client #4 held client #7's feet to his face and was moaning. Client #4 was restrained. No injury.</p> <p>-On 4/23/12 at 5:30 PM, client #4 grabbed a community member's feet while at a church dinner. Client #4</p>				

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	<p>"dove" under a table next to where the clients and staff were sitting to grab a woman's feet who was not wearing shoes. At first, client #4 was just touching her feet and the woman pulled her feet away. The woman was asked to move away but she kept putting her feet toward client #4 and moving her toes. Client #4 was restrained. An as needed medication was given. The woman was not injured.</p> <p>-On 4/27/12 at 6:20 PM, client #4 grabbed client #5's bare feet. Client #4 was restrained due to not releasing his feet when prompted. No injury. Staff trained to prompt clients to wear shoes and socks.</p> <p>-On 4/28/12 at 4:15 PM, client #4 attempted to destroy a board game his peers were playing in the dining room. Client #6 indicated client #4 punched him in the stomach as client #6 tried to stop client #4 from destroying the game; this was not observed by staff. Client #4 was restrained and then released when calm. Client #1 walked past client #4 and client #4 grabbed his coat and would not release the coat. Client #1 punched client #4 on the side of the head using the side of his fist. No injury.</p> <p>-On 4/28/12 at 7:30 PM, client #4 grabbed onto client #7's feet after client</p>						

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	<p>#7 took off his TED hose and shoes while sitting in his recliner in the living room. Client #7 refused to leave his TED hose and shoes on. Client #4 grabbed client #7's feet and held them up to his face. Client #4 would not release client #7's feet so a restraint was used. No injury.</p> <p>-On 5/9/12 at 2:15 PM, client #3 threw a water bottle while in the van hitting client #7 on the left shoulder. No injury. The investigative report, dated 5/15/12, indicated, "There is evidence to support that [client #3] had thrown a water bottle and accidentally hit [client #7] in the left shoulder."</p> <p>-On 6/19/12 at 7:30 PM, client #2 and staff #3 were going through client #2's clothes at the request of his guardian. The guardian requested that client #2 donate clothes to the homeless shelter. Per the report, "[Client #2] suddenly became angry evidenced by becoming verbally abusive towards [staff #3] and suddenly pushing her into the fire extinguisher located in the hallway outside of [client #2's] door. [Client #2] scraped his arm on the fire extinguisher while pushing [staff #3] into it. [Client #2] slit his arm on the hanger of the fire extinguisher. [Client #2] was taken to the ER (emergency room) to be examined... received nine stitches in his arm." The report indicated,</p>						

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	"This appears to be an isolated incident. [Client #2] does not have a history of being physically or verbally aggressive with others. [Client #2's] guardian stated on 6/19/12 following the incident that [client #2] becomes upset when getting rid of clothes or items. This was not known until after the incident." The Plan to Resolve section indicated the following, "An IDT (Interdisciplinary Team) meeting is in the process of being scheduled. [Client #2's] ISP (Individual Support Plan) will be revised to address this incident and prevent such incidents from occurring if agreed upon (sic) all team members." On 6/21/12 at 8:00 PM, client #2 was discovered to have bruising on the upper inside of both of his arms. The report indicated, "Through the investigation regarding [6/19/12 incident] it was discovered on 6/21/12 that staff used an inappropriate hold on [client #2]." The investigative report indicated, "There is evidence to support that an inappropriate hold was used on [client #2] during the time of the incident (on 6/19/12). There is evidence to support that the least restrictive physically (sic) intervention was not used. There is evidence to support that the bruising on [client #2's] arms is consistent to the hold used." The investigative report did not include the corrective action taken with staff #3 to address the use of an			

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	<p>inappropriate hold.</p> <p>A review of the facility's abuse and neglect policy, dated April 2011, was conducted on 6/26/12 at 3:12 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." The policy indicated, "Indiana MENTOR programs maintain a written list of rights, which take into account the requirements of applicable laws, regulations, and purchasing agencies. This list of rights should include, but is not limited to: e. Ensure the clients are not subjected to physical, verbal, sexual, or psychological abuse or punishment... o. The following actions are prohibited by employees of Indiana MENTOR: 1) abuse, neglect, exploitation or mistreatment of an individual including misuse of an individual's funds. 2) violation of an individual's rights."</p> <p>An interview with Quality Assurance (QA) staff was conducted on 6/27/12 at 1:17 PM. QA staff indicated client to client aggression was considered abuse.</p> <p>An interview with the Program Director (PD) was conducted on 7/2/12 at 10:57</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G300	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/02/2012
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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151
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	<p>AM. The PD indicated client #4 grabbing other's feet was abuse due to being contact between client #4 and his peers. The PD indicated the staff have been trained on how to prevent abuse between the clients.</p> <p>An interview with the Area Director (AD) was conducted on 6/29/12 at 12:21 PM. The AD indicated client to client aggression was abuse and should be prevented by staff.</p> <p>9-3-2(a)</p>			

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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151			
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W0154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 2 of 43 incident/investigative reports reviewed affecting clients #2 and #4, the facility failed to ensure thorough investigations were conducted into incidents of 1) property destruction and physical aggression toward staff involving client #4 and 2) the use of an inappropriate restraint on client #2.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 6/26/12 at 2:43 PM and 6/28/12 at 9:42 AM.</p> <p>1) On 6/12/12 at 8:39 PM, client #4 signed "food" and staff assisted him in the kitchen with getting food. He "suddenly" began slamming his foot into the wastebasket in the kitchen and ran back and forth on the main level of the group home signing "food." Staff attempted to communicate with client #4 to ascertain what food he wanted to eat. Staff then prompted client #4 to get the food he wanted. Client #4 took everything out of the refrigerator and threw it on the floor or in the trash. The report indicated he was engaged in property destruction and</p>	W0154	The Program Director received retraining on completing thorough investigations which include any corrective action as applicable, by the Area Director on 7/23/2012. All future investigations will be reviewed for completeness and thoroughness by the Area Director and Quality Assurance Specialist. Responsible Party: Program Director, Area Director, and Quality Assurance Specialist	08/01/2012			

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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151			
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	<p>physical aggression toward staff. Client #4 "appeared to be thinking of eloping." He stripped down his clothes and was looking out windows and doors. Staff blocked the exits of the home when he attempted to elope. Staff had approval to administer his as needed (PRN) medication however the staff were unable to administer due to client #4's behavior. Staff attempted to physically intervene, but were unsuccessful. Staff got him to his room after trying to physically restrain him. Client #4 began to "destroy" his room and bang his head on the window. Staff successfully restrained client #4 and he was administered the PRN, however at the incorrect dose (1 milligram (mg) of Ativan instead of 2 mg). The report indicated, "In the meantime, 911 was contacted." Officers and medical personnel arrived and asked staff to release him. Client #4 was restrained by the officers and placed him in handcuffs long enough for him to calm down. Client #4 was then sedated by emergency personnel and transported to the hospital. He was admitted to the crisis care unit.</p> <p>The investigative report, dated 6/18/12, indicated the following in the conclusion, "There is evidence to support that [client #4's] BDP (Behavior Development Program) was followed by staff and their supervisor. There is evidence to support</p>						

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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151			
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	<p>that [client #4] was obsessing over feet for at least five minutes straight. There is evidence to support that [client #4's] Ativan was administered upon Program Director's approval. There is also evidence to support that the PRN was effective." There was no documentation in the interviews with staff who witnessed the incident (staff #1, #3, #9, #10, #11, #12 and #14) client #4 was obsessing over feet. The incident report and the investigative report indicated client #4 had been obsessing over food. The conclusion did not address client #4 being administered a half dose of his PRN medication. The conclusion indicated the PRN was effective however client #4 had to be restrained, per the investigative report, by 4 police officers and then handcuffed. The investigative report indicated client #4 was sedated by emergency personnel prior to being transported to the hospital.</p> <p>A review of client #4's record was conducted on 6/28/12 at 1:15 PM. Client #4's BDP, dated 6/8/12, indicated he had the following targeted behaviors: <i>Physical Assault</i> - Attempted or actual purposeful attacks directed at other people that may include striking, kicking, pulling hair, violently pulling clothing or glasses, biting or throwing objects. <i>Destroys Property</i> - Purposely damages own,</p>						

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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151
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	<p>peer's, agency's or public property resulting in a minor or major replacement cost. <i>Self-Injurious Behavior</i> - Purposely inflicts a blow or bite to self that causes noticeable marking to the body.</p> <p><i>Inappropriate Nudity</i> - Engages in partial or full nudity or genital exposure in view of others in inappropriate locations within the group home setting or other location.</p> <p><i>Stealing</i> - Taking, using, ingesting or otherwise rendering less useful another's belongings when permission was coerced or not given. <i>Inappropriate Food-Seeking</i> - Begins to go after food that one would not usually eat by itself such as: butter, sour cream, and other non-food items. <i>Vacating</i> - Vacating will be defined to occur only at times when [client #4] is scheduled to be in to a specified environment (e.g., group home, day program) as outlined within [client #4's] program plan. Running away is defined as leaving a program area and not returning when called. <i>Obsessing</i> - Showing excessive preoccupation with a single topic such as televisions, fax machines, calendars, Colts shirts and feet.</p> <p><i>Inappropriate Sexual Behavior</i> - Touching of or showing of genitals in non-private areas or without consent. Attempts to touch other 's feet." The BDP indicated the following PRN plan, "[Client #4's] PRN lorazepam (Ativan) was increased on 6/8/12 to 2 mg up to</p>			

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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151
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	<p>every 30 minutes not to exceed four doses in a 24 hour period."</p> <p>2) On 6/19/12 at 7:30 PM, client #2 and staff #3 were going through client #2's clothes at the request of his guardian. The guardian requested that client #2 donate clothes to the homeless shelter. Per the report, "[Client #2] suddenly became angry evidenced by becoming verbally abusive towards [staff #3] and suddenly pushing her into the fire extinguisher located in the hallway outside of [client #2's] door. [Client #2] scraped his arm on the fire extinguisher while pushing [staff #3] into it. [Client #2] slit his arm on the hanger of the fire extinguisher. [Client #2] was taken to the ER (emergency room) to be examined... received nine stitches in his arm." The report indicated, "This appears to be an isolated incident. [Client #2] does not have a history of being physically or verbally aggressive with others. [Client #2's] guardian stated on 6/19/12 following the incident that [client #2] becomes upset when getting rid of clothes or items. This was not known until after the incident." The Plan to Resolve section indicated the following, "An IDT (Interdisciplinary Team) meeting is in the process of being scheduled. [Client #2's] ISP (Individual Support Plan) will be revised to address this incident and prevent such incidents</p>			

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	<p>from occurring if agreed upon (sic) all team members." On 6/21/12 at 8:00 PM, client #2 was discovered to have bruising on the upper inside of both of his arms. The report indicated, "Through the investigation regarding [6/19/12 incident] it was discovered on 6/21/12 that staff used an inappropriate hold on [client #2]." The investigative report indicated, "There is evidence to support that an inappropriate hold was used on [client #2] during the time of the incident (on 6/19/12). There is evidence to support that the least restrictive physically (sic) intervention was not used. There is evidence to support that the bruising on [client #2's] arms is consistent to the hold used." The investigative report did not include the corrective action taken with staff #3 to address the use of an inappropriate hold.</p> <p>An interview with the Area Director (AD) was conducted on 7/2/12 at 11:14 AM. The AD stated, "I wouldn't count it thorough" when the information in the conclusion did not match the body of the investigative report. The AD indicated the incident involving client #4 on 6/12/12 did not involve obsessing over feet. The AD indicated client #4 was obsessing over food. The AD indicated the PRN med was not administered when permission was received from the PD due</p>			

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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151			
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	<p>to the staff dealing with the behavior. The AD indicated the PRN was not administered at the correct dose and was not effective since client #4 was sedated by emergency personnel. The AD indicated the corrective action recommended during an investigation should be included in the investigation.</p> <p>An interview with the Program Director (PD) was conducted on 7/2/12 at 10:57 AM. The PD indicated the information in the conclusion should match the information in the body of the investigation. The PD indicated if the information does not match the body of the investigation then it was not completely thorough. The PD indicated the information in the conclusion of client #4's incident on 6/12/12 was from another investigation. The PD indicated there was no information client #4 was obsessing over feet. The PD stated of the conclusion, "it was a complete error" and "not sure how it was missed."</p> <p>9-3-2(a)</p>						

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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151			
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W0159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>Based on record review and interview for 2 of 4 clients in the sample (#1 and #2), the Qualified Mental Retardation Professional (QMRP - called Program Director) failed to ensure: 1) client #2's Individual Support Plan (ISP) was implemented timely, 2) the workshop staff received training on clients #1 and #2's program plans and the group home and the workshop had a communication system in place, and 3) the clients were supervised during the morning drop off at the workshop.</p> <p>Findings include:</p> <p>1) A review of client #2's record was conducted on 6/28/12 at 12:11 PM. Client #2's ISP was dated 2/22/12. A review of client #2's monthly summaries for February, March, April and May indicated the ISP training goals developed in February were not implemented until May 2012.</p> <p>An interview with the Program Director (PD) was conducted on 6/28/12 at 1:15 PM. The PD indicated the training objectives developed in February 2012</p>	W0159	<p>TSI is committed to ensuring outside services meet the needs of each client. The workshop staff for clients 1 and 2 have been trained on clients plans. A plan has been developed between this workshop and TSI to ensure all staff working with these clients are trained on their plans on an ongoing basis. This plan includes ensuring that substitute staff are also trained prior to working with these clients. The Program Director and Home Manager complete at least monthly observations and have been trained to check with day services staff to ensure all current client plans are available and accessible to all day services staff that work with the clients. Management staff will ensure that clients plans are current and updated as plans change. Communication books have been initiated for all clients and their respective day services to ensure daily communication. Staff in the home were trained on 7/2/2012 and 7/19/2012 on how to manage communication books for all clients in the home. Day Program staff were trained on 7/19/2012 on the use of communication book daily. These communication books are</p>	08/01/2012			

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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151		
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	<p>were not implemented until May 2012. The PD indicated the training objectives should have been implemented in February when the ISP was held. The PD stated, "I was late in getting those implemented."</p> <p>2) An observation was conducted on 6/27/12 from 6:05 AM to 8:04 AM at the group home. At 6:33 AM, client #1 became upset. Client #1 indicated a peer at the workshop kept staring at him. Direct care staff (DCS) #5 asked client #1 what he should do when he became upset. Client #1 stated he should "calm down." DCS #5 prompted client #1 to take a deep breath and he did. Client #1 indicated he was calm. DCS #5 prompted client #1 to change his shirt (same shirt he wore during the evening observation on 6/26/12) and shave his whiskers. Client #1 indicated he was getting upset and did not want to change his shirt. DCS #1 prompted client #1 when he finished his meds he was going to remain calm, "make the wind blow," and have a good day. At 6:38 AM, DCS #5 indicated she needed to inform the other staff working at the home not to prompt client #1 anymore regarding changing his shirt and shaving. DCS #1 indicated if client #1 was prompted more than three times, he may become physically aggressive.</p>		<p>monitored by management staff at least weekly to ensure they are used daily by staff and day servcies.Management staff have been trained on how to document weekly monitoring of these communication books.Staff were trained on 6/29/2012 on supervising clients to their designated area in the workshop each day they attend and not just drop clients off at the door.Management staff will complete random morning transport observations to ensure staff are following this procedure.Responsible Party: Program Director, Area Director, and Quality Assurance Specialist</p>		

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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151			
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	<p>An observation was conducted at the workshop clients #1 and #2 attended on 6/27/12 from 9:37 AM to 10:49 AM. At 9:48 AM, client #2 was sleeping at his workstation. Workshop supervisor #1 woke client #2 and he worked the remainder of the observation. Client #1 was out of the work area upon arrival. Client #1 returned to the work area at 9:50 AM from a walk. Client #1 alternated between working and walking around the room.</p> <p>A review of client #1's record was conducted on 6/28/12 at 11:42 AM. Client #1's ISP was dated 4/13/12. His Behavior Development Plan (BDP) was dated 2/9/12.</p> <p>A review of client #2's record was conducted on 6/28/12 at 12:11 PM. Client #2's ISP was dated 2/22/12. Client #2's ISP indicated, "[client #2] does NOT have Behavior Support Services."</p> <p>An interview with workshop supervisor (WS) #1 was conducted on 6/27/12 at 9:48 AM. WS #1 indicated client #1 had been yelling at WS (substitute staff) #2 prior to the surveyor's arrival to the workshop. WS #1 indicated she was not informed client #1 had been agitated at the group home on the morning of 6/27/12 but this information would have</p>						

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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151		
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	<p>been good to know. WS #1 indicated the production area clients #1 and #2 worked had many substitute staff working in the area. WS #1 indicated there was no communication book between the group home and the workshop.</p> <p>A review of clients #1 and #2's plans at the workshop was conducted on 6/27/12 at 10:12 AM. The plans available to the workshop staff located in a binder in the workshop administrator #1's (WA) office were not the current plans. Client #1 and #2's Individual Support Plans were dated 2011. Client #1's Behavior Development Plan (BDP) was also dated 2011. WA #1 indicated the Program Director (PD) from the group home had sent her the current plans however she was unable to locate them initially. The WA printed off the plans from her email on her computer. The WA, on 6/27/12 at 10:14 AM, indicated she was unable to locate training documentation for the staff working in the workshop. She stated the staff were "always" in training and the substitute staff were "always" with a familiar, trained staff.</p> <p>An interview with WA #2 was conducted on 6/27/12 at 10:23 AM. WA #2 indicated the workshop did not have a written procedure in place for training staff.</p>				

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	<p>An interview with the workshop's Human Resources (HR) staff #1 was conducted on 6/27/12 at 10:38 AM. HR #1 indicated there was no written policy/procedure in place for the workshop staff to be trained on the clients' plans. HR #1 indicated the system currently in place did not work. HR #1 indicated she had never seen staff training documentation for the workshop staff. HR #1 indicated she was told the workshop had their own binders for training documentation and the information was not submitted to HR. HR #1 indicated HR should have the training documentation. HR #1 indicated each workshop staff's employee file should have training documentation on client-specific training.</p> <p>An interview with the workshop's HR staff #2 was conducted on 6/27/12 at 10:49 AM. HR #2 indicated she was unable to locate documentation the staff (both regular staff and substitute) received training on client #1 and #2's program plans.</p> <p>An interview with Quality Assurance (QA) staff for the group home was conducted on 6/27/12 at 12:59 PM. The QA staff indicated there should be a communication book between the group</p>						

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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151
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	<p>home and the workshop. The QA staff indicated the Program Director (PD) for the group home should train the supervisor of the workshop and then the supervisor would then train the workshop staff.</p> <p>An interview with the Program Director (PD) for the group home was conducted on 6/27/12 at 1:00 PM. The PD indicated a communication book would be a good way for the staff at the workshop and group home to communicate. The PD indicated the PD and home manager should provide training to the administrator at the workshop at then the administrator should train the workshop staff. The PD indicated if the workshop did not provide training then the group home staff should provide the training to the workshop staff. The PD indicated she had not provided training to the administrator of the workshop or the staff at the workshop. The PD indicated the clients' plans should be accessible to the workshop staff.</p> <p>An interview with the Area Director (AD) was conducted on 6/29/12 at 12:21 PM. The AD indicated communication books between the workshop and the group home should be in place. The AD indicated the group home staff need to ensure the workshop staff received</p>			

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	<p>training on the clients' plans. The AD indicated the clients' plans should be accessible to the workshop staff.</p> <p>3) An observation was conducted at the workshop clients #1 and #2 attended on 6/27/12 from 9:37 AM to 10:49 AM. At 9:48 AM, client #2 was sleeping at his workstation. Workshop supervisor #1 woke client #2 and he worked the remainder of the observation. Client #1 was out of the work area upon arrival. Client #1 returned to the work area at 9:50 AM from a walk. Client #1 alternated between working and walking around the room the remainder of the observation.</p> <p>A review of client #1's record was conducted on 6/28/12 at 11:42 AM. Client #1's Individual Support Plan (ISP) was dated 4/13/12. His Behavior Development Plan (BDP) was dated 2/9/12. The BDP indicated he had the following targeted maladaptive behaviors: refusals, physical aggression, vacating, temper outbursts, property destruction and hair removal. His ISP indicated he required 24 hour supervision.</p> <p>A review of client #2's record was conducted on 6/28/12 at 12:11 PM. Client #2's ISP was dated 2/22/12. Client #2's ISP indicated, "[client #2] does NOT</p>						

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	<p>have Behavior Support Services." His ISP indicated he required 24 hour supervision.</p> <p>An interview with Workshop Supervisor (WS) #1 was conducted on 6/27/12 at 9:52 AM. WS #1 indicated when she arrived on 6/27/12, she observed the group home staff dropping off clients #1 and #2. WS #1 indicated the group home staff did not exit the car and did not escort/supervise clients #1 and #2 to their work area. WS #1 indicated the clients were dropped off routinely without a staff supervising them to their work area at the workshop. WS #1 indicated client #2 had issues with coming to the work area in the mornings. WS #1 indicated client #2 stopped in the cafeteria located upstairs at the facility and bought a soda each morning making him late to work. WS #1 indicated the group home staff needed to walk/supervise the clients to their work area in the mornings.</p> <p>An interview with the group home Program Director (PD) was conducted on 6/27/12 at 1:04 PM. The PD indicated clients #1 and #2 should be supervised by the group home staff to their work areas at the workshop. The PD indicated neither should be unsupervised. The PD indicated the group home was responsible for the clients' supervision until the clients</p>						

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	<p>get to their program area.</p> <p>An interview with the group home Area Director (AD) was conducted on 6/29/12 at 12:21 PM. The AD indicated the group home staff should be walking in with the clients to ensure they go to their program area (workshop).</p> <p>9-3-3(a)</p>				

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W0227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN 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 2 of 4 clients in the sample (#1 and #2), the facility failed to ensure there were plans addressing: 1) client #2's behavior related to discarding old, unused, ill-fitting clothes and 2) client #1's fast pace and stuffing mouth during meals.</p> <p>Findings include:</p> <p>1) A review of the facility's incident/investigative reports was conducted on 6/26/12 at 2:43 PM and 6/28/12 at 9:42 AM. On 6/19/12 at 7:30 PM, client #2 and staff #3 were going through client #2's clothes at the request of his guardian. The guardian requested that client #2 donate clothes to the homeless shelter. Per the report, "[Client #2] suddenly became angry evidenced by becoming verbally abusive towards [staff #3] and suddenly pushing her into the fire extinguisher located in the hallway outside of [client #2's] door. [Client #2] scraped his arm on the fire extinguisher while pushing [staff #3] into it. [Client #2] slit his arm on the hanger of the fire</p>	W0227	Client 2's IDT met to address an incident involving discarding old items. Behavior guidelines were developed, his ISP was revised to include this plan. Staff have been trained on this plan and to report any problems or concerns. Client 1's IDT met to address food intake and him eating quickly during meals. His ISP was updated following this IDT, a training objective was developed and staff have been trained on implementing this training objective to ensure client 1's safety. Day Program has been trained on Client 1's plan and monitoring his mealtime safety. The Program Director will monitor all clients interactions and will meet with client's IDT's as needed to address any concerns. Responsible Party: Program Director, Area Director, and Quality Assurance Specialist	08/01/2012			

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	<p>extinguisher. [Client #2] was taken to the ER (emergency room) to be examined... received nine stitches in his arm." The report indicated, "This appears to be an isolated incident. [Client #2] does not have a history of being physically or verbally aggressive with others. [Client #2's] guardian stated on 6/19/12 following the incident that [client #2] becomes upset when getting rid of clothes or items. This was not known until after the incident." The Plan to Resolve section indicated the following, "An IDT (Interdisciplinary Team) meeting is in the process of being scheduled. [Client #2's] ISP (Individual Support Plan) will be revised to address this incident and prevent such incidents from occurring if agreed upon (sic) all team members."</p> <p>A review of client #2's record was conducted on 6/28/12 at 12:11 PM. Client #2's ISP was dated 2/22/12. There was no documentation in client #2's record indicating his ISP had been updated to address donating or throwing away clothes or items.</p> <p>An interview with the Behavior Consultant (BC) was conducted on 6/29/12 at 11:41 AM. The BC indicated she was asked to develop a plan to address client #2's issues with donating or throwing away personal items. The BC</p>						

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	<p>indicated the plan had not been developed and implemented. The BC indicated the guidelines would be submitted to the facility by the end of the day on 6/29/12.</p> <p>An interview with the Home Manager (HM) was conducted on 6/29/12 at 12:21 PM. The HM indicated client #2's plan to address getting rid of old clothes/items had not been implemented.</p> <p>An interview with the Area Director (AD) was conducted on 6/29/12 at 12:21 PM. The AD indicated client #2's plan to address getting rid of old clothes/items had not been implemented. The AD indicated the BC was submitting the plan by the end of the day on 6/29/12.</p> <p>2) Observations were conducted at the group home on 6/26/12 from 4:04 PM to 6:30 PM and 6/27/12 from 6:05 AM to 8:04 AM. On 6/26/12 at 5:50 PM, client #1 sat down to eat dinner. Client #1 ate large bites at a fast pace and placed more stir fry into his mouth prior to swallowing the food in his mouth. Client #1 continued eating in this manner until he finished his meal at 6:04 PM. Client #1 was not prompted by staff #1, #5, #8 #12 or the PD to slow down and chew his food before putting more food into his mouth.</p>				

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	<p>A review of client #1's record was conducted on 6/28/12 at 11:42 AM. Client #1's record did not have a plan to address his large bites, fast pace and placing more food into his mouth prior to swallowing the food in his mouth.</p> <p>An interview with the Program Director (PD) was conducted on 6/27/12 at 12:52 PM. The PD was unsure if client #1's had a plan addressing his dining issues. The PD indicated he needed verbal prompting to slow down his pace.</p> <p>An interview with Quality Assurance staff (QA) was conducted on 6/27/12 at 12:52 PM. QA staff indicated there was no plan in client #1's record addressing stuffing and fast pace. QA staff indicated he did not need a formal plan but then indicated he needed continuous prompting to slow down. QA staff indicated client #1 did not have a history of choking.</p> <p>An interview with the AD was conducted on 6/29/12 at 12:21 PM. The AD indicated client #1 ate fast and needed a plan. The AD indicated the plan could include using a napkin between bites.</p> <p>9-3-4(a)</p>						

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W0322	<p>483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care.</p> <p>Based on record review and interview for 1 of 4 clients in the sample (#4), the facility failed to ensure client #4 had an annual physical.</p> <p>Findings include:</p> <p>A review of client #4's record was conducted on 6/28/12 at 1:15 PM. Client #4's record indicated his most recent annual physical was conducted on 5/9/11.</p> <p>An interview with the Home Manager (HM) was conducted on 6/28/12 at 1:53 PM. The HM indicated client #4's annual physical was scheduled twice however client #4 was hospitalized at a crisis unit on both scheduled appointments. The HM indicated client #4's annual physical was overdue.</p> <p>9-3-6(a)</p>	W0322	<p>TSI is committed to providing and obtaining preventative and general medical care. Client 4 received his annual physical on 7/17/2012. Staff had set this appointment for Client 4 two times, however, he was hospitalized during both scheduled appointment times and they had to be rescheduled. The nurses track updated annual dental and physical dates every month and forward the dates to the Area Director. The Area Director will follow up with the Program Director on any missing documentation to ensure completion each month. Responsible Party: Area Director, Program Director.</p>	08/01/2012			