

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G436	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/16/2015
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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11 WASHINGTON ST BROWNSBURG, IN 46112
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W 0000 Bldg. 00	<p>This visit was for a pre-determined full annual recertification and state licensure survey.</p> <p>Dates of Survey: 7/13/15, 7/14/15, 7/15/15 and 7/16/15</p> <p>Facility Number: 000950 Provider Number: 15G436 AIMS Number: 100244690</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9</p>	W 0000		
W 0102 Bldg. 00	<p>483.410 GOVERNING BODY AND MANAGEMENT</p> <p>The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, record review and interview, the facility failed to meet the Condition of Participation: Governing Body for 2 of 4 sampled clients (#1 and #4). The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility met the Condition of Participation: Health Care Services. The</p>	W 0102	<p>Area Director will retrain the Program Director on BDDS reporting criteria; including reporting skin integrity issues. Clinical Nursing Director will retrain Facility Nurse on documentation standards related to immediately following medical recommendations and aggressively monitoring and preventing skin integrity issues. Facility Nurse has developed a</p>	08/15/2015

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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	<p>governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility immediately notified the BDDS (Bureau of Developmental Disabilities Services) regarding an incident of skin breakdown for client #1 and an incident of skin breakdown for client #4 and to ensure the facility's nursing services aggressively monitored and prevented clients #1 and #4 from developing pressure ulcers.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility immediately notified the BDDS regarding an incident of skin breakdown for client #1 and an incident of skin breakdown for client #4 and to ensure the facility's nursing services aggressively monitored and prevented clients #1 and #4 from developing pressure ulcers. Please see W104. 2. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility met the Condition of Participation: Health Care Services. Please see W318. <p>9-3-1(a)</p>		<p>protocol for monitoring and preventing pressure ulcers for client 1 documentation standards have been added to clients 1 medication administration record for staff ongoing verification that the above protocol was followed per established frequency. Client 4 was discharged into a nursing home facility July 7,2015. Facility Nurse reviewed charts of all clients in the home to identify if any additional clients require skin integrity protocols for monitoring and prevention. On 7/30/15 staff was formally trained on the protocol for client 1 pressure sores and the required documentation related to following the protocol per established frequency. Facility Nurse will conduct record review at minimum twice weekly, Program Director and Program Coordinator will each conduct a record review at minimum weekly for 30 days to ensure documentation is completed per established protocol. Program Coordinator will complete active treatment observations at minimum 3 times weekly for 30 days to ensure medical protocols are being followed and implemented as</p>	

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W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review and interview for 2 of 4 sampled clients (#1 and #4), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility immediately notified the BDDS (Bureau of Developmental Disabilities Services) regarding an incident of skin breakdown for client #1 and an incident of skin breakdown for client #4 and to ensure the facility's nursing services aggressively monitored and prevented clients #1 and #4 from developing pressure ulcers.</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility immediately notified the BDDS regarding an incident of skin breakdown for client #1 and an incident of skin breakdown for client #4. Please see</p>	W 0104	<p>trained/written. Ongoing, Facility Nurse, Program Coordinator and Program Director will each complete medical record review and observation at minimum weekly.</p> <p>Area Director will retrain the Program Director on BDDS reporting criteria; including reporting skin integrity issues. Clinical Nursing Director will retrain Facility Nurse on documentation standards related to immediately following medical recommendations and aggressively monitoring and preventing skin integrity issues. Facility Nurse will conduct record review at minimum twice weekly, Program Director and Program Coordinator will each conduct a record review at minimum weekly for 30 days to ensure documentation is completed per established protocol.</p> <p>Client 4 was discharged into a nursing home facility July 7, 2015. Facility Nurse reviewed charts of all clients in the home to identify if</p>	08/15/2015

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W 0318 Bldg. 00	<p>W9999.</p> <p>2. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility nursing services aggressively monitored and prevented clients #1 and #4 from developing pressure ulcers. Please see W331.</p> <p>9-3-1(a)</p> <p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on observation, record review and interview, the facility failed to meet the Condition of Participation: Health Care Services for 2 of 4 sampled clients (#1 and #4). The facility health care services failed to aggressively monitor and prevent clients #1 and #4 from developing pressure ulcers.</p>	W 0318	<p>any additional clients require skin integrity protocols for monitoring and prevention. On 7/30/15 staff was formally trained on the protocol for client 1 pressure sores and the required documentation related to following the protocol per established frequency. Facility Nurse, Program Director and Program Coordinator will each conduct a record review at minimum weekly for 30 days to ensure documentation is completed per established protocol. Program Coordinator will complete active treatment observations at minimum 3 times weekly for 30 days to ensure medical protocols are being followed and implemented as trained/written. Ongoing, Facility Nurse, Program Coordinator and Program Director will each complete medical record review and observation at minimum weekly.</p> <p>Clinical Nursing Director will retrain Facility Nurse on documentation standards related to immediately following medical recommendations and aggressively monitoring and preventing skin integrity issues. Facility Nurse has developed a protocol for monitoring and preventing pressure ulcers for</p>	08/15/2015

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	<p>Findings include:</p> <p>The facility health care services failed to aggressively monitor and prevent clients #1 and #4 from developing pressure ulcers. Please see W331.</p> <p>9-3-6(a)</p>		<p>client 1 documentation standards have been added to clients 1 medication administration record for staff ongoing verification that the above protocol was followed per established frequency. Client 4 was discharged into a nursing home facility July 7,2015. Facility Nurse reviewed charts of all clients in the home to identify if any additional clients require skin integrity protocols for monitoring and prevention. On 7/30/15 staff was formally trained on the protocol for client 1 pressure sores and the required documentation related to following the protocol per established frequency. Facility Nurse will conduct record review at minimum twice weekly, Program Director and Program Coordinator will each conduct a record review at minimum weekly for 30 days to ensure documentation is completed per established protocol. Program Coordinator will complete active treatment observations at minimum 3 times weekly for 30 days to ensure medical protocols are being followed and implemented as trained/written. Ongoing, Facility Nurse, Program Coordinator and</p>	

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W 0331 Bldg. 00	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 2 of 4 sampled clients (#1 and #4), the facility nursing services failed to aggressively monitor and prevent clients #1 and #4 from developing pressure ulcers.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 7/15/15 at 8:07 AM. Client #1's Medical Appointment Form (MAF) dated 6/1/15 indicated, "Reason for visit: Exam for sore." Client #1's 6/1/15 MAF indicated, "No evidence of active or open bed sores. Recommend frequent repositioning and use of donut cushion if needed. Return to office for any open or draining lesions. Right hip area with 1 centimeter decubitus."</p> <p>Client #1's Nursing Progress Note (NPN) narrative entry dated 6/4/15 did not indicate documentation of review of client #1's 6/1/15 MAF recommendations for repositioning, or use of a donut cushion. The 6/4/15 NPN did not indicate</p>	W 0331	<p>Program Director will each complete medical record review and observation at minimum weekly.</p> <p>Clinical Nursing Director will retrain Facility Nurse on documentation standards related to immediately following medical recommendations and aggressively monitoring and preventing skin integrity issues. Facility Nurse has developed a protocol for monitoring and preventing pressure ulcers for client 1 documentation standards have been added to clients 1 medication administration record for staff ongoing verification that the above protocol was followed per established frequency. Client 4 was discharged into a nursing home facility July 7,2015. Facility Nurse reviewed charts of all clients in the home to identify if any additional clients require skin integrity protocols for monitoring and prevention. On 7/30/15 staff was formally trained on the protocol for client 1 pressure sores and the required documentation related to following the protocol per established frequency. Facility Nurse will conduct record review at minimum twice weekly, Program Director and Program Coordinator will each conduct a</p>	08/15/2015

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	<p>documentation of nursing measures, or pressure ulcer protocol to prevent the sore on client #1's right hip area from developing into a pressure ulcer.</p> <p>Client #1's MAF dated 6/10/15 indicated, "Reason for visit: Physical exam." The 6/10/15 MAF indicated, "Right buttocks decubitus ulcer. Refer to [wound care specialist]. Continue duoderm (wound dressing) for now...."</p> <p>Client #1's NPN narrative entry dated 6/11/15 indicated, "To group home to assess wound (on) right hip. Area approximately 1" by 1" by 0.4 centimeters deep. Wound bed red with light brown surrounding tissue. No drainage or odor noted from area. [Client #1] seen by PCP (Primary Care Physician) on 6/10/15 with referral to wound care specialist ordered. To see [doctor] on 6/18/15. Wound care in-service education provided to group home staff. Staff instructed to encourage change of positions every 2 hours, keeping client off right hip, especially at night."</p> <p>Client #1's In-service Form completed by RN (Registered Nurse) #1 on 6/11/15 indicated, "Encourage her to change positions, turning from back to left side, every 2 hours during the night and</p>		<p>record review at minimum weekly for 30 days to ensure documentation is completed per established protocol. Program Coordinator will complete active treatment observations at minimum 3 times weekly for 30 days to ensure medical protocols are being followed and implemented as trained/written. Ongoing, Facility Nurse, Program Coordinator and Program Director will each complete medical record review and observation at minimum weekly.</p>	

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	<p>encourage her to stay off her right hip as much as possible. Open areas are usually caused by pressure on the area. Please clean her up when incontinent. Use soap and water to keep her skin clean, keep her skin well moisturized with a good moisturizing lotion. Until she sees the wound specialist later this week, keep the open area covered with the Duoderm, changing it every 3 days and PRN if loose and/or soiled. Please monitor her skin at least twice daily and notify the program nurse promptly with any re/open/ areas of concern so that treatment can be started as soon as possible. Please notify the program nurse promptly if any drainage and/or odor (are) noted from the area."</p> <p>Client #1's MAF dated 6/18/15 indicated, "Reason for visit: Wound exam." Client #1's MAF dated 6/18/15 indicated, "Home health care nurses to see [client #1] twice a week and PRN (As Needed), hydrogel gel... to right post hip stage III ulcer, needs alternating pressure mattress, needs Roho low profile cushion and follow up in 2 weeks."</p> <p>Client #1's MAR (Medication Administration Record) dated 6/1/15 through 6/30/15 indicated, "Start 6/11/15: Turn every two hours at night in bed (12 am, 2 am, 4 am and 6 am)."</p>			

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	<p>Client #1's MAR dated 7/1/15 through 7/15/15 (date of review) did not indicate documentation of client #1's repositioning schedule for night hours. Client #1's MAR dated 7/1/15 through 7/15/15 indicated client #1 should be encouraged to toilet every 2 hours during the day.</p> <p>Client #1's record did not indicate documentation of a risk plan or pressure ulcer protocol.</p> <p>Observations were conducted at the group home on 7/14/15 from 3:50 PM through 5:30 PM and on 7/15/15 from 6:10 AM through 8:00 AM. Client #1 did not utilize a donut or other cushion or have an alternating pressure mattress.</p> <p>HM (Home Manager) #1 was interviewed on 7/15/15 at 8:45 AM. HM #1 indicated client #1 had a pressure ulcer on her right hip area. HM #1 indicated home health nurses had been coming the home twice a week to provide care for client #1's pressure ulcer. HM #1 indicated client #1 did not have an alternating pressure mattress or cushion due to Medicaid funding issues. HM #1 indicated the facility was in the process of acquiring the alternating pressure mattress and cushion but had not received the items at</p>			

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	<p>the time of review.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 7/15/15 at 8:50 AM. QIDP #1 indicated client #1 had not received an alternating pressure mattress or cushion. QIDP #1 indicated client #1 should be repositioned every 2 hours at night. QIDP #1 indicated there was not documentation of a risk plan or written protocol regarding client #1's wound care or prevention measures.</p> <p>2. Client #4's record was reviewed on 7/15/15 at 9:18 AM. Client #4's Monthly Health Review (MHR) for February 2015 indicated, "2/25/15: left buttocks reddened, but not open, staff turning [client #4]/changing positions every 2 hours throughout the day/night...."</p> <p>Client #4's In-service Form completed by RN #1 on 2/6/15 indicated, "[Client #4] had a red area at the base of his spine, just inside his buttocks (coccyx) that requires frequent monitoring. At this time, it is closed and I need to be notified if it becomes open. I would like to implement the following: his position is to be changed every 2 hours. During the night, he is to be turned every 2 hours with a pillow placed at his back to keep him from rolling over. I have added this to the MAR. During the day, he is to be</p>			

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	<p>moved every 2 hours from the wheelchair to a char and from side to side to keep weight off his coccyx. He must be cleaned up promptly, using soap and water with clean clothes and Depends (adult diapers) provided, as soon as he found wet or dirty. I have requested an order from his PCP for a barrier cream to be applied to the red area any time he is cleaned up to keep the area dry. His skin is to be monitored at least twice daily and, if the area is found to be open or the red area increasing, please notify me as soon as this is noted."</p> <p>Client #4's MAF dated 5/15/15 indicated, "Reason for visit: Sores on his bottom. Has stage II decubitus ulcer in pre sacral region (buttocks)." The MAF dated 5/15/15 indicated, "Try to reposition him frequently to avoid putting direct pressure on ulcer area."</p> <p>Client #4's MHR dated May 2015 indicated, "5/21/15, 9:45 AM: stage II decubitus ulcer sacral area, Duoderm in place, no signs/symptoms of infection noted/reported, staff has been cueing client to change positions at least every 2 hours and turning him every 2 hours throughout the night."</p> <p>Client #4's record did not indicate documentation of a risk plan or pressure</p>			

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W 9999 Bldg. 00	<p>ulcer protocol.</p> <p>RN #1 was interviewed on 7/15/15 at 11:00 AM. RN #1 indicated client #1 was seen on 6/1/15 for a sore at her PCP and on 6/10/15 for a pressure ulcer. RN #1 indicated there was not documentation of nursing measures implemented after client #1's 6/1/15 PCP visit. RN #1 indicated on 6/11/15 she had completed an in-service with staff regarding client #1's wound specialist recommendations but had not developed a formal risk plan or nursing protocol regarding pressure ulcers. RN #1 indicated client #1 did not have an alternating pressure mattress or cushion due to Medicaid funding issues. RN #1 indicated she had completed an in-service with staff regarding client #4's pressure ulcer on 2/6/15 but had not developed a formal risk plan or nursing protocol regarding pressure ulcers.</p> <p>9-3-6(a)</p>	W 9999	Area Director will retrain the Program Director on BDDS	08/15/2015
	State Findings			

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	<p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met.</p> <p>460 IAC 9-3-1 Governing Body (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by division: (14) (f) "any occurrence of skin breakdown related to a decubitus ulcer, regardless of severity."</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 2 of 2 incidents of skin breakdown reviewed, the facility failed to immediately notify the BDDS (Bureau of Developmental Disabilities Services) regarding an incident of skin breakdown for client #1 and an incident of skin breakdown for client #4.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 7/15/15 at 8:07 AM. Client #1's Medical Appointment Form (MAF) dated 6/10/15 indicated, "Reason for visit: Physical</p>		<p>reporting criteria; including reporting skin integrity issues and the requirement to notify the BDDS coordinator no later than the 1st business day following the incident. Facility Nurse reviewed charts of all clients in the home to identify if any additional clients require skin integrity protocols for monitoring and prevention. Facility Nurse will immediately notify the Program Nurse at the instant that a consumer is identified as having skin integrity concerns. These issues will also be documented in the monthly nursing note reviewed and signed off by the Program Director.</p>	

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	<p>exam." The 6/10/15 MAF indicated, "Right buttocks decubitus ulcer. Refer to [wound care specialist]. Continue duoderm (wound dressing) for now...."</p> <p>HM (Home Manager) #1 was interviewed on 7/15/15 at 8:45 AM. HM #1 indicated client #1 had a pressure ulcer on her right hip area.</p> <p>2. Client #4's record was reviewed on 7/15/15 at 9:18 AM. Client #4's Monthly Health Review (MHR) dated 5/15/15 indicated, "Reason for visit: Sores on his bottom. Has stage II decubitus ulcer in pre sacral region (buttocks)."</p> <p>The facility's BDDS reports and investigations were reviewed on 7/13/15 at 1:50 PM. The review did not indicate client #1's 6/10/15 and/or client #4's 5/15/15 skin breakdown incidents had been reported to BDDS.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 7/15/15 at 8:50 AM. QIDP #1 indicated clients #1 and #4's incidents of skin breakdown had not been reported to BDDS.</p> <p>9-3-1(b)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G436	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/16/2015
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 11 WASHINGTON ST BROWNSBURG, IN 46112		
(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	