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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G298 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 11/01/2011 |
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| NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC | STREET ADDRESS, CITY, STATE, ZIP CODE 317 N MAIN ST HAUBSTADT, IN47639 |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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 |
|--------------------|--|---------------|--|----------------------|
| W0000 | <p>This visit was for a recertification and state licensure survey.</p> <p>Survey dates: 10/19, 10/20, 10/21, 10/24 and 11/1/11</p> <p>Facility Number: 000817 Provider Number: 15G298 AIM Number: 100243700</p> <p>Surveyor: Jenny Ridao, Medical Surveyor III</p> | W0000 | | |
| W0227 | <p>This deficiency also reflects state findings in accordance with 460 IAC 9. Quality Review completed 11-29-11 by C. Neary, Program Coordinator. 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. Based on interview and record review for 1 of 4 sampled clients (#2), the client's Individual Support Plan (ISP) failed to address the client's identified education training need on the causes and prevention of STDs (Sexually Transmitted Diseases).</p> <p>Findings include: Review of the facility's Bureau of</p> | W0227 | <p>An IDT meeting was held on 12/5/11 to discuss the need for adding a goal to Client #2's programming reviewing Sexually Transmitted Diseases. The team recommended adding a goal at this time to teach Client #2 the symptoms of Chlamydia. On 12/7/11, the new goal was implemented with Client #2 to teach her the symptoms of Chlamydia. The Program Director will monitor this goal on a monthly basis for</p> | 12/08/2011 |

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>Developmental Disabilities Services (BDDS) reports on 10/24/11 at 11 AM indicated: "On 3/5/11 [Client #2] snuck her boyfriend into the group home and was unsupervised in her bedroom with him for approximately ten minutes."</p> <p>Client #2's record was reviewed on 10/24/11 at 3:30 PM. Client #2's March 2011's nurses notes indicated client #2 was taken to the gynecologist on 3/7/11 and tested positive for the STD Chlamydia. Review of client #2's 10/18/11 ISP did not include any goals regarding what an STD is and how to prevent contracting an STD.</p> <p>Interview with client #2 on 10/24/11 at 1 PM indicated she was sexually active with her boyfriend. Client #2 indicated she snuck her boyfriend into her bedroom through the window so they could be alone. Client #2 stated "I don't know what an STD is, but I had something wrong down there (in her private area) and didn't even know it." When asked if client #2 knew what an STD was and how to prevent it, client #2 stated "No."</p> <p>Interview with Administrative staff #1 on 10/24/11 at 4:45 PM indicated client #2's ISP did not include any objectives pertaining to the education of STDs.</p> | | <p>progress.Responsible Party: Program Director and Home Manager</p> | | |

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| | 1.1-3-4(a) | | | | |