

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G394		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/02/2012	
NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 701 RILEY BLVD BEDFORD, IN 47421			
(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>Paper compliance was completed 12/4/11 for the Fundamental Certification and State Licensure survey completed 11/4/11.</p> <p>Facility Number: 000908 Provider Number: 15G394 AIMS Number: 100244380</p> <p>Surveyor: Steve Corya, Surveyor Supervisor</p> <p>Tags Corrected: W336 Not Corrected W198</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G394		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/02/2012	
NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 701 RILEY BLVD BEDFORD, IN 47421			
(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			
W0198	<p>Clients who are admitted by the facility must be in need of and receiving active treatment services.</p> <p>A review of client #2's record was conducted on 11/3/11 at 10:12 AM. -His Individualized Support Plan (ISP), dated 9/22/11, indicated client #2 was emancipated. The ISP indicated his diagnoses included Mild mental retardation and mental disorder due to traumatic brain injury. The ISP indicated the dining skills assessment indicated he was independent. The ISP indicated he could independently care for his glasses and solve problems (in most areas). The ISP indicated he was independent in the following areas: safely mixing water, evacuating during fire drills, perform household tasks, personal hygiene and leisure skills. The ISP indicated he had the following training objectives: participate in at least one community activity each week, exercise for 10 minutes at least three times per week, complete daily household chore, thoroughly clean bedroom one time per week, complete all steps to do his laundry, prepare a side dish for dinner one time per week, work with job coach to obtain community employment, administer as needed medications, complete a page out of his math</p>	W0198	<p>Client #2 received level of care for Medicaid Waiver. Pretransition has been completed, the tentative move in date to a waiver setting is April 1, 2012.</p>	04/01/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G394	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 701 RILEY BLVD BEDFORD, IN 47421
---	--

(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>workbook two times per week, write a budget and put back at least 10% of his check to save to purchase larger items, and earn weekend privileges when he exhibits no targeted behaviors for the entire week.</p> <p>-Client #2's progress on his training objectives in May 2011 indicated 100% success rate.</p> <p>-Client #2's progress on his training objectives in June 2011 indicated 100% success rate with the exception of 95% for hygiene.</p> <p>-Client #2's progress on his training objectives in July 2011 indicated 100% success rate for hygiene, behavior and 96% for personal safety skills.</p> <p>-Client #2's progress on his training objectives in August 2011 indicated 100% success rate with the exception of a 90% for community safety skills and 92% for math skills.</p> <p>-Client #2's progress on his training objectives in September 2011 indicated 100% success rate with the exception of 90% for community safety skills and 86% for math skills.</p> <p>-The Hot Water Temperature Control assessment, dated 9/29/11, indicated he was independent in all aspects of controlling the temperature of water.</p> <p>-The Community Orientation Assessment, dated 9/29/11, indicated client #2 was independent in all areas except acting</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G394	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 701 RILEY BLVD BEDFORD, IN 47421
---	--

(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>appropriately in a normal public situation. The assessment indicated he was able to give his home address and phone number, use a public phone and restroom, use public transportation, cross the street safely, use a phone book, call for help if lost, identify stores and what they sell and walk or ride to a familiar place over 1.4 miles away.</p> <p>-The Pedestrian Safety Test, dated 9/29/11, indicated he was independent at identifying traffic lights and crosswalk lights and, stop, yield, danger, keep out, information, enter and exit, no trespassing, and telephone signs.</p> <p>-The Pro-Social Skills Assessment, dated 9/29/11, indicated client #2 could do the following: listening to others, ask for help, follow instructions, complete assignments, contribute to discussions, offer help to a supervisor, ask questions, make corrections, deciding on something to do, set a goal, introduce himself, begin and end a conversation, join in an activity, play a game, ask for a favor, offer help to a peer, give and accept a compliment, suggest an activity, identify feelings, recognize another's feelings, express concern for another, reward himself, ask permission, accept consequences, negotiate, deal with boredom, make a complaint, deal with losing, showing good sportsmanship under winning and losing conditions, dealing with</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G394		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/02/2012	
NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 701 RILEY BLVD BEDFORD, IN 47421			
(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>embarrassment, react to failure, say no, deal with group pressure, and make a thoughtful decision.</p> <p>-The Camelot Behavioral Checklist, dated 9/29/11, indicated he was independent in the following areas: eating, dressing and undressing, toileting, knowledge of self, bathing, hair care, grooming (except brushing teeth and shaving), balance, walking, posture, body movements, hand movements, sensory development, house cleaning, clothing care, cooking, yard care, care maintenance, operation of appliances, work related skills, job skills, shopping (except "resists 'high pressure' sales"), transportation, time, expressive language, reading (except remembering what he read), writing, using telephone, spectator activities, participation, response to emergencies and security.</p> <p>-The Informed Consent - Skills List, dated 9/29/11, indicated client #2 was able to give photograph consent, assist in financial affairs (except prioritizing decisions regarding expenditures, budgeting, and maintaining savings and checking accounts independently), release of information, endangered adults, resident rights, interdisciplinary team membership, behavior assessment, house rules, medical treatment, supervision level, grievance policy and procedure, and human rights committee membership.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G394	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 701 RILEY BLVD BEDFORD, IN 47421
---	--

(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>An interview with direct care staff (DCS) #4 was conducted on 11/2/11 at 4:57 PM. Staff #4 indicated client #2 needed to be in a higher functioning group home. She indicated he had complained to her numerous times about not fitting in at the group home with his peers. DCS #4 indicated client #2 needed more peer interaction. DCS #4 indicated client #2 was independent in most areas.</p> <p>An interview with DCS #7 was conducted on 11/2/11 at 5:12 PM. DCS #7 indicated client #2 did not fit in at the home due to being much higher functioning than the other clients. DCS #7 indicated client #2 wanted to be out doing things and going places but was unable to do so since his peers liked to stay home. DCS #7 stated client #2 "can do everything, nothing he can't do." DCS #7 indicated client #2 did not need to be in a group home. DCS #7 stated client #7 was "very smart." DCS #7 indicated client #2 discussed with her several times about being frustrated in his current living situation.</p> <p>An interview with client #2's co-worker (maintenance staff) was conducted on 11/2/11 at 3:28 PM. His co-worker indicated client #2 was a great worker. He indicated he had no issues or concerns with client #2's job performance or behavior. He indicated client #2 carries</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G394	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/02/2012
NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 701 RILEY BLVD BEDFORD, IN 47421		
(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>his own money. He indicated client #2 did not fit in with the rest of the clients at the group home due to being higher functioning than everyone else. Client #2 had expressed his concerns to him multiple times and indicated he did not fit in. Client #2's co-worker indicated client #2 was a quick learner and great in social situations. Client #2's co-worker stated client #2, "knows no strangers."</p> <p>An interview with the home manager (HM) was conducted on 11/3/11 at 11:12 AM. The HM stated client #2 was "really high functioning" for the home. The HM indicated client #2's peers were much lower functioning. The HM indicated client #2 would be happier in a higher functioning home. The HM indicated he was able to do most things independently however he, at times, refuses to do so. The HM indicated he was able to read, cook, administer as needed medications, call 911 and would not sign anything unless he read it first. The HM indicated transportation was the main area of client #2's staff dependence.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 11/3/11 at 11:12 AM. The QMRP stated client #2 was a "good waiver candidate." He needs some support but would be a better fit with</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G394	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 701 RILEY BLVD BEDFORD, IN 47421
---	--

(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>higher functioning peers. The QMRP indicated he completed most tasks with minimal assistance.</p> <p>9-3-4(a)</p>			
--	--	--	--	--