

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G410	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/03/2012
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 103 E HANCOCK MITCHELL, IN 47446		
(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	
W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Survey Dates: November 27, 28, 29, 30 and December 3, 2012.</p> <p>Facility Number: 000924 Provider Number: 15G410 AIM Number: 100244510</p> <p>Surveyor: Steven Schwing, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review was completed on 12/7/12 by Tim Shebel, 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G410		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/03/2012	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 103 E HANCOCK MITCHELL, IN 47446			
(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			
W0137	<p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>Based on record review and interview for 3 of 4 clients in the sample (#1, #2 and #6), the facility failed to ensure the clients' personal possession inventories were updated annually and when purchases were made.</p> <p>Findings include:</p> <p>A review of client #1's record was conducted on 11/29/12 at 9:47 AM. Her Personal Possession Inventory, dated June 2010, had not been updated. A review of client #1's finances was conducted on 11/28/12 at 12:11 PM. In July 2012, client #1 purchased 2 pairs of jeans on 7/19/12 and \$228.38 of clothes on 7/23/12. On 7/31/12, client #1 purchased shoes and assorted items at a shoe store in the amount of \$252.40. On 7/31/12, client #1 purchased a night stand and chest of drawers for \$390.55. These items were not documented on client #1's inventory. Client #1's inventory had not been updated since 2010.</p> <p>A review of client #2's record was conducted on 11/29/12 at 10:47 AM.</p>	W0137	Program Directors and Home Managers will be retrained on adequate updating of clients' personal inventories to include updates as purchases are made as well as annual updates. Staff will be trained as well on the guidelines for updating clients' personal inventories on 1/18/13.	01/02/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G410		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/03/2012	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 103 E HANCOCK MITCHELL, IN 47446			
(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>Client #2's Personal Possession Inventory was dated 6/15/10. Client #2's inventory had not been updated since 2010.</p> <p>A review of client #6's record was conducted on 11/29/12. Client #6's Personal Possession Inventory was dated 3/15/10. On 7/17/12, client #6 purchased a nightstand and mattress protector in the amount of \$310.41. These items were not documented on client #6's inventory. Client #6's inventory had not been updated since 2010.</p> <p>An interview with the Home Manager (HM) was conducted on 11/29/12 at 9:51 AM. The HM indicated the items the clients purchased in July 2012 were not added to each clients' inventory.</p> <p>An interview with the Program Director (PD) was conducted on 11/29/12 at 9:51 AM. The PD stated it was "unrealistic" for the group home to update the clients' inventories for every item of clothing purchased. The PD indicated she was not aware of how often the clients' inventories should be updated.</p> <p>An interview with the Area Director (AD) was conducted on 11/29/12 at 10:22 AM. The AD indicated the clients' inventories should be completed upon admission, annually and any time a purchase was</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G410	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/03/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 103 E HANCOCK MITCHELL, IN 47446
---	--

(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
	made. 9-3-2(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G410		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/03/2012	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 103 E HANCOCK MITCHELL, IN 47446			
(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			
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. Based on record review and interview for 5 of 22 incident/investigative reports reviewed affecting 7 of 8 clients (#1, #2, #3, #5, #6, #7 and former client #8), the facility neglected to implement its policies and procedures to prevent client to client abuse.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 11/27/12 at 11:04 AM.</p> <p>1) On 9/23/12 at 11:00 AM, former client #8 pushed client #5 causing client #5 to fall. Staff were able to break client #5's fall and client #5 was not injured.</p> <p>2) On 7/5/12 at 7:30 AM, former client #8 hit client #3 on her arm/wrist. Client #3 was not injured.</p> <p>3) On 5/17/12 at 8:25 AM at the day program, staff heard a slapping sound and observed client #6's hand on client #1's back. Client #1 grabbed client #6's wrist and squeezed it causing redness on client #6's wrist.</p> <p>4) On 3/31/12 at 9:00 PM, former client #8 hit and kicked client #7. Client #7 was not injured.</p> <p>5) On 2/14/12 at 8:15 PM, client #2 hit</p>	W0149	Direct Care Staff will be retrained on company policy and techniques to utilize pertaining to the prevention of client to client abuse. Observations of direct care staff working with clients will be randomly completed by management staff at least 1 time per week to monitor staff's implementation of this policy.	01/02/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G410	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/03/2012
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 103 E HANCOCK MITCHELL, IN 47446		
(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>client #6 with an open hand. Client #6 was not injured.</p> <p>A review of the facility's abuse and neglect policy, dated April 2011, was conducted on 11/27/12 at 10:57 AM. 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 Administrative Staff (AS) #2 was conducted on 11/27/12 at 12:23 PM. AS #2 indicated client to client aggression was considered and treated as abuse. AS #2 indicated the group home staff should prevent abuse of</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G410	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/03/2012
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 103 E HANCOCK MITCHELL, IN 47446		
(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>the clients, including client to client aggression.</p> <p>An interview with AS #1 was conducted on 11/29/12 at 12:50 PM. AS #1 indicated client to client aggression was abuse. AS #1 indicated the staff should prevent abuse of the clients.</p> <p>9-3-2(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G410		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/03/2012	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 103 E HANCOCK MITCHELL, IN 47446			
(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			
W0159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview for 4 of 4 clients in the sample (#1, #2, #4 and #6), the Qualified Mental Retardation Professional (called Program Director - PD) failed to 1) convene a team meeting to discuss client #6's refusals to participate in a hearing exam and develop a desensitization plan, 2) revise client #2's program objective for dental needs based on recommendations by the dentist, 3) ensure the clients' binders in the group home contained the current program plans for 3 of 4 sample clients (#1, #2 and #4) and 4) review client #2's use of hearing aids.</p> <p>Findings include:</p> <p>1) A review of client #6's record was conducted on 11/29/12 at 12:09 PM. Client #6 had two attempts of a hearing evaluation on 6/11/10 and 9/21/10. Client #6 was uncooperative for both exams. On 10/27/11, the nurse documented in a quarterly nursing note the following, in part, "Discussed with [client #6's] mother ABR (auditory brainstem response) hearing. Does not want [client #6] to undergo anesthesia unless life</p>	W0159	<p>IDT Meetings will be held to address clients' refusals to participate in hearing exam, utilization of hearing aids, and dental recommendations regarding teeth brushing. Following each client's IDT to address issues, goals and plans will be updated accordingly. Program Director and Home Manager will be retrained on policy and procedure regarding IDT meetings and when these meetings are necessary. Program Director and Home Manager will be retrained on policy and procedure pertaining to having current plans in the house for direct care staff to access. Management staff will complete Supervisory Checklist of the in house books for at least 1 client every 2 weeks chosen at random to ensure the most current plans are in the home.</p>	01/02/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G410		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/03/2012	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 103 E HANCOCK MITCHELL, IN 47446			
(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>threatening/or severe need. Canceled appointment. Did agree to ENT (ear nose and throat) appointment but would like to attend. IDT (Interdisciplinary team) meeting scheduled for 11/18/11. [Client #6's] current fx (functioning) level and abilities are not hampered by his hearing. Will work on desensitization program for appointments at IDT meeting." Client #6's record did not contain an IDT meeting on 11/18/11. There was no documentation in client #6's Individual Support Plan (ISP), dated 10/25/12, of a desensitization program for hearing. The ISP indicated client #6's most recent hearing assessment was "deferred." Client #1's ISP did not indicate client #6 refused to participate or cooperate with his hearing assessment.</p> <p>An interview with the PD was conducted on 11/29/12 at 12:50 PM. The PD was unable to locate an IDT dated 11/18/11 for client #6 addressing a desensitization plan for his hearing assessments. On 11/30/12 at 3:07 PM, the PD indicated a desensitization plan was not developed. The PD indicated client #6 needed a plan.</p> <p>2) A review of client #2's record was conducted on 11/29/12 at 10:47 AM. On 10/12/12, client #2 was seen by his dentist. The Dental Examination Report indicated in the oral hygiene instructions,</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G410	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/03/2012
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 103 E HANCOCK MITCHELL, IN 47446		
(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>"Poor oral hygiene. Needs to brush longer." The additional comments indicated, "Rec (recommend) pt (patient) brush to music for 1 whole song - since he enjoys music." Client #2's ISP, dated 6/26/12, indicated client #2 had a formal program objective to brush his teeth thoroughly, for 2 minutes, two times per day. There was no documentation in client #2's record indicating the dentist's recommendation were discussed by the team and implemented in client #2's program plan.</p> <p>An interview with the Home Manager (HM) was conducted on 11/29/12 at 12:50 PM. The HM indicated there was no written plan for client #2 to brush his teeth while listening to music.</p> <p>An interview with the Area Director (AD) was conducted on 11/29/12 at 12:50 PM. The AD indicated the dentist's recommendations should have been incorporated into client #2's dental hygiene plan.</p> <p>An interview with the PD was conducted on 11/30/12 at 3:07 PM. The PD indicated she could not recall if the dentist's recommendations were reviewed. The PD indicated client #6's program plan was not revised to include the dental recommendations. The PD indicated</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G410	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/03/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 103 E HANCOCK MITCHELL, IN 47446
---	--

(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>client #6's plan should have been revised.</p> <p>3) The records reviewed were from the group home and the records the staff would use to access the clients' current program plans.</p> <p>A review of client #1's record was conducted on 11/29/12 at 9:47 AM. The ISP in client #1's group home binder was dated 9/29/11. Client #1's current ISP was dated 9/29/12.</p> <p>A review of client #2's record was conducted on 11/29/12 at 10:47 AM. The ISP in client #2's group home binder was dated 6/26/11. Client #2's current ISP was dated 6/26/12. Client #2's Behavior Support Plan (BSP) in the binder was dated 10/1/10. Client #2's current BSP was dated 10/1/11.</p> <p>A review of client #4's record was conducted on 11/29/12 at 11:19 AM. Client #4's BSP in the record was dated 10/5/10. The facility did not provide client #4's current BSP for review during the survey. The current BSP was requested during the review of client #4's record and on 11/30/12 at 1:40 PM.</p> <p>A review of the Quarterly Health and Safety Assessment, dated 9/30/12, was conducted on 11/29/12 at 11:15 AM. The</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G410		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/03/2012	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 103 E HANCOCK MITCHELL, IN 47446			
(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>report indicated for Q (quarter) 4, "7 of 8 ISPs are not current in books. The discrepancies from Q3 have still not been resolved."</p> <p>An interview with the Program Director (PD) was conducted on 11/29/12 at 10:41 AM. The PD indicated the group home binders should have the clients' current plans for staff to access. The PD indicated client #4's BSP was not the current BSP.</p> <p>An interview with the Area Director (AD) was conducted on 11/29/12 at 12:50 PM. The AD indicated the clients' binders in the group home should have the current plans for staff to review.</p> <p>4) A review of client #2's record was conducted on 11/29/12 at 10:47 AM. On 9/16/11 client #2 had a hearing test. The recommendations indicated client #2 had normal-to-severe loss with good speech discrimination. The report indicated he was eligible to obtain new hearing instruments. An Interdisciplinary Team (IDT) Meeting form, dated 10/5/11, indicated the following, "The team is meeting to discuss whether or not to obtain new hearing aids for [client #2] as he is eligible for a new pair. The team believes it would be best to hold off on new hearing aids at this time. We will</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G410	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/03/2012
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 103 E HANCOCK MITCHELL, IN 47446		
(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>revisit this issue in one year." There was no documentation the team revisited this issue in October 2012 or any other month. Client #2's Individual Support Plan (ISP), dated 6/26/12, indicated, "Hearing aids are recommended but IDT on 10/5/11 decided that due to [client #2's] continuous refusal to wear and b/c (because) guardian believes that the hearing aids cause add't (additional) delusional behaviors, [client #2's] wearing of hearing aids will not be enforced or encouraged at this time. Team will readdress in 1 year." There was no documentation in client #2's record indicating the team convened to discuss client #2's use of hearing aids one year after the 10/5/11 IDT meeting.</p> <p>An interview with the PD was conducted on 11/29/12 at 12:50 PM. The PD indicated client #2 should have a plan to wear his hearing aids. On 11/30/12 at 3:07 PM, the PD indicated an IDT meeting was not held in October 2012 to discuss client #2's hearing aids. The PD indicated the team should have convened to discuss client #2's hearing aids.</p> <p>9-3-3(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G410		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/03/2012	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 103 E HANCOCK MITCHELL, IN 47446			
(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			
W0209	<p>483.440(c)(2) INDIVIDUAL PROGRAM PLAN Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate. Based on record review and interview for 1 of 4 clients in the sample (#1), the facility failed to ensure client #1's guardian was present and contributed to the development of her Individual Support Plan (ISP).</p> <p>Findings include:</p> <p>A review of client #1's record was conducted on 11/29/12 at 9:47 AM. Client #1's ISP, dated 9/29/12, did not include a signature on the ISP's Statement of Agreement from client #1's guardian. There was no documentation the guardian attended or participated in the ISP annual meeting.</p> <p>An interview with the Program Director (PD) was conducted on 11/30/12 at 2:02 PM. The PD indicated client #1's guardian did not attend her annual ISP meeting. The PD indicated she was unable to contact the guardian. The PD indicated the home manager also attempted to contact the guardian however she was unsuccessful in reaching the guardian. The PD indicated the guardian did not give input for client #1's</p>	W0209	Program Directors will be retrained on policy pertaining to required guardian participation in annual planning and IDT meetings. Program Director will send out Invite List to Area Director for review prior to annual meetings.	01/02/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G410	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/03/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 103 E HANCOCK MITCHELL, IN 47446
---	--

(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>program plan. The PD indicated the guardian should be present or give input for the development of client #1's program plan.</p> <p>9-3-4(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G410		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/03/2012	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 103 E HANCOCK MITCHELL, IN 47446			
(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			
W0248	<p>483.440(c)(7) INDIVIDUAL PROGRAM PLAN</p> <p>A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on record review and interview for 3 of 4 clients in the sample (#1, #2 and #4), the facility failed to ensure the clients' current plans were available to the direct care staff at the group home.</p> <p>Findings include:</p> <p>The records reviewed were from the group home and the records the staff would use to access the clients' current program plans.</p> <p>A review of client #1's record was conducted on 11/29/12 at 9:47 AM. The ISP in client #1's group home binder was dated 9/29/11. Client #1's current ISP was dated 9/29/12.</p> <p>A review of client #2's record was conducted on 11/29/12 at 10:47 AM. The ISP in client #2's group home binder was dated 6/26/11. Client #2's current ISP was dated 6/26/12. Client #2's Behavior Support Plan (BSP) in the binder was dated 10/1/10. Client #2's current BSP was dated 10/1/11.</p>	W0248	<p>Program Director will be retrained on policy and procedure pertaining to having current plans in the house for direct care staff to access. Direct Care Staff will be trained on all plans prior to their implementation and placement into the group home. Monthly reviews of the program books will be completed by Program Director or Home Manager to ensure all current plans are in clients' books.</p>	01/02/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G410		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/03/2012	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 103 E HANCOCK MITCHELL, IN 47446			
(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>A review of client #4's record was conducted on 11/29/12 at 11:19 AM. Client #4's BSP in the record was dated 10/5/10. The facility did not provide client #4's current BSP for review during the survey. The current BSP was requested during the review of client #4's record and on 11/30/12 at 1:40 PM.</p> <p>A review of the Quarterly Health and Safety Assessment, dated 9/30/12, was conducted on 11/29/12 at 11:15 AM. The report indicated for Q (quarter) 4, "7 of 8 ISPs are not current in books. The discrepancies from Q3 have still not been resolved."</p> <p>An interview with the Program Director (PD) was conducted on 11/29/12 at 10:41 AM. The PD indicated the group home binders should have the clients' current plans for staff to access. The PD indicated client #4's BSP was not the current BSP.</p> <p>An interview with the Area Director (AD) was conducted on 11/29/12 at 12:50 PM. The AD indicated the clients' binders in the group home should have the current plans for staff to review.</p> <p>9-3-4(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G410		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/03/2012	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 103 E HANCOCK MITCHELL, IN 47446			
(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			
W0249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review and interview for 1 of 4 clients in the sample (#6), the facility failed to ensure staff implemented client #6's plan for choking, as written.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 11/28/12 from 2:47 PM to 5:20 PM. At 5:01 PM, client #6 sat down to eat dinner prior to the other clients and staff. Client #6 received prompts initially from staff to not shovel his food, take a drink, wipe his face and take one bite at a time. At 5:03 PM, client #6 was left unsupervised in the dining room while he ate for 2 minutes. While unsupervised, client #6 ate bite after bite of his pureed dinner without taking a drink while his head and mouth were down next to his plate. At 5:05 PM, the Home Manager (HM) reentered the dining room and immediately prompted him to slow down. The HM stated to client #7, "He only has one speed, doesn't he?" At 5:08 PM,</p>	W0249	House Manager and Direct Care Staff will be retrained on client's current dining plan and high risk plans, including his choking plan. House Manager or Program Director will complete weekly observations of direct care including during mealtime to ensure plans are being followed for four weeks followed by monthly observations after 4 weeks.	01/02/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G410	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/03/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 103 E HANCOCK MITCHELL, IN 47446
---	--

(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>client #1 stated to client #6, "You're all done already?" Staff did not sit next to client #6 when he ate his first servings of his dinner. Staff did not encourage client #6 to swallow before the next bite or use hand over hand assistance for him to slow down. Staff did not encourage client #6 to sit up straight during the meal.</p> <p>A review of client #6's record was conducted on 11/29/12 at 12:09 PM. An Aspiration Protocol, dated 1/28/12, indicated, "[Client #6] had diagnosis of choking, difficulty swallowing; he is on a pureed diet and nectar thickened liquids. [Client #6] eats fast and does not take time to chew food." The plan indicated, "Staff to sit beside [client #6] when he eats. Remind him to slow down when he eats. Staff to place hand on hand when needed to slow down." Client #6's Choking Protocol, dated 1/28/12, indicated, in part, "Staff remind to eat at a slower rate and to swallow before next bite. Staff to remind not to everfill mouth. Staff to encourage sips of liquid often to clear mouth of food." Client #6's Dining Plan, dated 1/28/12, indicated, in part, "Staff to remind/encourage [client #6] to slow down when eating. Staff to sit beside [client #6] and place hand over hand as needed to slow pace, and to encourage [client #6] to sit up straight."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G410	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/03/2012
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 103 E HANCOCK MITCHELL, IN 47446		
(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 the Home Manager (HM) was conducted on 11/29/12 at 12:50 PM. The HM indicated the staff should have implemented client #6's dining plan as written.</p> <p>An interview with the Area Director (AD) was conducted on 11/29/12 at 12:50 PM. The AD indicated client #6 should have been supervised during his meal since he had a plan for choking.</p> <p>An interview with the Program Director (PD) was conducted on 11/30/12 at 3:07 PM. The PD indicated the staff should have implemented client #6's plans as written.</p> <p>9-3-4(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G410		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/03/2012	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 103 E HANCOCK MITCHELL, IN 47446			
(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			
W0263	<p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on record review and interview for 1 of 4 clients in the sample (#1), the facility's specially constituted committee (HRC) failed to ensure consent was obtained from client #1's guardian for her Individual Support Plan (ISP).</p> <p>Findings include:</p> <p>A review of client #1's record was conducted on 11/29/12 at 9:47 AM. Client #1's ISP, dated 9/29/12, indicated client #1 had a guardian. The ISP, with a restriction to knives/sharps, did not include consent for the implementation of the plan from her guardian.</p> <p>An interview with the Program Director (PD) was conducted on 11/29/12 at 12:50 PM. The PD indicated consent should be obtained from the guardian annually or when the plan was revised. The PD indicated the guardian was not responding to phone calls or emails. The PD indicated she was unable to receive consent from client #1's guardian prior to the ISP being implemented.</p>	W0263	<p>Program Director and HRC Members will be retrained on policy to include obtaining guardian approval prior to giving HRC approval in compliance with state guidelines. For receiving approval from guardians who are unable to be contacted, certified letters will be mailed requesting their signature and approval.</p>	01/02/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G410	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/03/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 103 E HANCOCK MITCHELL, IN 47446
---	--

(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
	9-3-4(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G410		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/03/2012	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 103 E HANCOCK MITCHELL, IN 47446			
(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			
W0436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on record review and interview for 1 of 4 clients in the sample with adaptive equipment (#2), the facility failed to ensure there was a plan in place to encourage and assist client #2 to wear his hearing aids.</p> <p>Findings include:</p> <p>A review of client #2's record was conducted on 11/29/12 at 10:47 AM. On 9/16/11 client #2 had a hearing test. The recommendations indicated client #2 had normal-to-severe loss with good speech discrimination. The report indicated he was eligible to obtain new hearing instruments. An Interdisciplinary Team (IDT) Meeting form, dated 10/5/11, indicated the following, "The team is meeting to discuss whether or not to obtain new hearing aids for [client #2] as he is eligible for a new pair. The team believes it would be best to hold off on new hearing aids at this time. We will revisit this issue in one year." There was no documentation the team revisited this issue in October 2012 or any other month.</p>	W0436	<p>IDT Meeting will be held to address client's current plan pertaining to wearing hearing aids per the recommendation of physician. Program Director will be retrained on policy and procedure regarding IDT meetings and when these meetings are necessary. For all decisions requiring future review by team, the ISP will be updated to ensure that these recommendations are reviewed at annual ISP meeting.</p>	01/02/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G410	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/03/2012
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 103 E HANCOCK MITCHELL, IN 47446		
(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>Client #2's Individual Support Plan (ISP), dated 6/26/12, indicated, "Hearing aids are recommended but IDT on 10/5/11 decided that due to [client #2's] continuous refusal to wear and b/c (because) guardian believes that the hearing aids cause add't (additional) delusional behaviors, [client #2's] wearing of hearing aids will not be enforced or encouraged at this time. Team will readdress in 1 year." The ISP did not include a plan for client #2 to wear his hearing aids.</p> <p>An interview with the Program Director (PD) was conducted on 11/29/12 at 12:50 PM. The PD indicated client #2 needed a plan to wear his hearing aids.</p> <p>9-3-7(a)</p>				