

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G435	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4155 RAY ST INDIANAPOLIS, IN 46241
---	--

(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
W 0000 Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: August 10, 11, 13, and 20, 2015.</p> <p>Facility number: 000949 Provider number: 15G435 AIM number: 100244680</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0125 Bldg. 00	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based upon observation, record review and interview, the facility failed to provide unrestricted access to the facility's kitchen area for 4 of 4 sampled clients (clients #1, #2, #3 and #4), and 4 additional clients (clients #5, #6, #7 and</p>	W 0125	Area Director will train Program Director on the formal process of assessment of client safety risks and restricting free access based on identified risk. This will include client assessment of risk, identification in Individual Support plan, intervention in Behavioral	09/20/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G435	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4155 RAY ST INDIANAPOLIS, IN 46241
---	--

(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>#8), without assessed need and due process.</p> <p>Findings include:</p> <p>During observations at the group home on 8/10/15 from 7:20 PM until 8:15 PM, on 8/11/15 from 6:15 AM until 8:30 AM and again on 8/11/15 from 4:20 PM until 5:30 PM, the kitchen had a locked half door to prevent access. During the 8/10/15 observation, the closet doors storing excess toiletry and first aid items (liquid soap peroxide, alcohol) and cleaning supplies were locked in the hallways near the clients' restrooms. During the 8/11/15 observations, clients #1, #2, #3, #4, #5, #6, #7 and #8 were unable to access the kitchen without staff using a key to unlock the door.</p> <p>Staff #4 was interviewed on 8/10/15 at 7:50 PM and stated the door to the kitchen was locked to "keep them from getting to the stove. Some of them might reach for the stove."</p> <p>The House Manager (HM) was interviewed on 8/10/15 at 7:55 PM. She indicated the door to the kitchen was locked to prevent access by client #7 who had been admitted from a locked facility in March, 2015. The HM stated client #7 "Will try to reach around and grab (at</p>		<p>Support plan, identification in Risk Management Plan and Human Right Approval. Also to include, plan for unimpeded access to other clients affected who does not present a risk. Program Director will complete assessment for client #3, #7 and all clients in the home to determine risk to free access to toiletries, kitchen/stove and patio area. Based on assessment and in conjunction with IDT; Program Director will include identified risk and restrictive access in Risk Management Plan, Individual Support Plan and intervention plan in Behavioral Support Plan. Program Director will include restriction of free access in the Individual Support Plan for all clients affected. This will include plan for unimpeded access to areas identified. Program Director will obtain Human Rights Approval for restrictive needs based on client assessment. Restrictions will be reviewed by HRC on a quarterly basis and annually with IDT to determine further need for restriction(s). Responsible Party: Area Director, Program Director</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G435	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4155 RAY ST INDIANAPOLIS, IN 46241
---	--

(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>food and the stove). She indicated client #3 will follow client #7 and imitate her actions and also needed to be restricted from the kitchen. The HM indicated the closet doors were now typically unlocked unless client #7 exhibited agitated behavior which was an indication she may try to access and drink inedible liquids. The HM stated clients #3 and #7 "will run," and the back patio gate was latched to prevent them from leaving.</p> <p>Client #3's record was reviewed on 8/11/15 at 3:10 PM and failed to identify an assessed need to prevent free access to the kitchen.</p> <p>Client #7's record was reviewed on 8/13/15 at 4:10 PM and indicated a targeted behavior of "stealing unauthorized food." Client #7's plan indicated "Door to kitchen and office have 1/2 doors to protect [client #7] from injuring herself from items. The intervention failed to indicate the doors were locked to prevent free access to the kitchen and stove. A Risk Management Assessment and Plan dated 2/4/15 failed to indicate an identified need to prevent access to the kitchen stove or a plan to regain unimpeded access to the kitchen. Client #7's BSP (Behavior Support Plan) dated 3/11/15 was reviewed on 8/13/15 at 6:00 PM and indicated target objectives</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G435	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4155 RAY ST INDIANAPOLIS, IN 46241
---	--

(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>of dropping to the ground and eating unauthorized food. There was no evidence in the record of a need to lock the back patio gate.</p> <p>Client #1's record was reviewed on 8/11/15 at 1:25 PM and failed to indicate a need to prevent access to the facility's kitchen or of a need to lock the back patio gate. Client #1's ISP (Individual Support Plan) dated 8/30/14 did not include an intervention to regain unimpeded access to the kitchen.</p> <p>Client #2's record was reviewed on 8/11/15 at 2:22 PM and failed to indicate a need to prevent access to the facility's kitchen or of a need to lock the back patio gate. Client #2's ISP (Individual Support Plan) dated 8/27/14 did not include an intervention to regain unimpeded access to the kitchen in the record.</p> <p>Client #4's record was reviewed on 8/13/15 at 3:35 PM and failed to indicate a need to prevent access to the facility's kitchen or of a need to lock the back patio gate. Client #4's ISP (Individual Support Plan) dated 12/2/14 did not include an intervention to regain unimpeded access to the kitchen.</p> <p>The facility's Human Right's Committee</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G435	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4155 RAY ST INDIANAPOLIS, IN 46241
---	--

(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
W 0159 Bldg. 00	<p>Agenda dated 8/13/15 was reviewed on 8/14/15 at 11:10 AM and indicated for clients #5, #7, #6, and #3, "Hygiene, Cleaning items, Kitchen half door, Office half door, and gate on back porch locked due to housemates behaviors."</p> <p>The Program Director was interviewed on 8/14/15 at 11:00 AM and indicated the facility's human rights committee had approved the secured doors. When asked about client #7's risk plan in regards to access to the stove, latched patio gate and cleaning supplies and toiletries, she stated, "I need to update them."</p> <p>9-3-2(a)</p> <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. Based upon observation, record review</p>	W 0159	Area Director will retrain Program Director on the review and	09/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G435	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4155 RAY ST INDIANAPOLIS, IN 46241
---	--

(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>and interview, the facility's QIDP (Qualified Intellectual Disabilities Professional) failed for 4 of 4 sampled clients (clients #1, #2, #3, and #4) to revise their objectives when progress was made or failed to be made, and failed to update client #1's active treatment schedule as needed.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 8/11/15 at 1:25 PM. Client #1's ISP (Individual Support Plan) dated 8/30/14 indicated objectives to spoon medications into her mouth with no more than 3 verbal prompts at 10% of trials attempted for three consecutive months, brush her teeth with hand over hand assistance with one physical prompt with 10% (unspecified) for three consecutive months, eat at least 4-5 bites with physical prompts at 50% (unspecified) for three consecutive months, participate in a leisure activity with a peer twice weekly in the PM independently in 100% of trials for three consecutive months, participate in community activities with staff monitoring at least once weekly in the PM with no more than 1 physical prompt, 100% of trials for three consecutive months, rub body with soap in the shower daily with no more than 1 physical prompt at 100% of trials for</p>		<p>revision on client goals and objectives based on their continued progress or inability to successfully complete the goal based on criteria set. This will include quarterly review of goal and systems for routine revision/review of the objectives. Area Director will retrain Program Director on updating clients Active Treatment schedule annually and as schedules require amendments-including date of schedule update. Program Director (QIDP) will review the goals and objectives of all clients in the home and revise objectives as needed based on clients continued progress or inability to successfully complete the goal. Program Director will update the Active Treatment Schedule for client #1 and review and update all clients' Active treatment in the home for any others identified. Ongoing, Program Coordinator will identify on their monthly summary that is submitted to the Program Director which clients require a goal/objective review for possible revision based on quarterly schedule set. Program Director (QIDP) will review and revise client objectives based on client progress. Program Director will submit Monthly Summaries to Area Director for review and revise objectives quarterly; which will be noted on the monthly summaries. Responsible Party: Area Director, Program Director,</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G435		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2015	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 4155 RAY ST INDIANAPOLIS, IN 46241			
(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>three consecutive months, and make a purchase in the community twice weekly with assistance from staff with 1 physical prompt 50% of trials for three consecutive months.</p> <p>A review by the QIDP for July, 2015 dated 8/9/15 of progress in client #1's objectives indicated the following:</p> <p>-0% progress to spoon medication into her mouth for 4/15, 5/15, 6/15 and 7/15.</p> <p>-100% progress to brush her teeth for 4/15, 5/15, 6/15 and 7/15.</p> <p>-100% progress to eat at least 4-5 bites for 4/15, 5/15, 6/15 and 7/15.</p> <p>-0% progress to participate in a leisure activity with a peer twice weekly for 4/15, 5/15, 6/15 and 7/15.</p> <p>-100% progress to participate in a community activity at least once weekly for 4/15, 5/15, 6/15 and 7/15.</p> <p>-100% progress to rub her body with soap for 4/15, 5/15, 6/15 and 7/15.</p> <p>-100% progress to make a community purchase two times weekly for 4/15, 5/15, 6/15 and 7/15.</p>		Program Coordinator.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G435	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4155 RAY ST INDIANAPOLIS, IN 46241
---	--

(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 recommendations for all the objectives indicated "Continue running objectives," with an action plan "PD (Program Director/QIDP) and HM (House Manager) to ensure that staff is running goals correctly." The note indicated client #1 attended day services one to two times weekly.</p> <p>Client #1's Active Treatment Schedule (undated) in the record indicated she was to attend day services Monday through Friday from 10:00 AM until 2:00 PM.</p> <p>2. During observations at the group home on 8/11/15 from 6:15 AM until 8:30 AM, client #2 asked the QIDP for her glasses which were kept in the medication administration area/office prior to leaving for day services. Client #2 placed them on her face independently. During medication administration at 7:00 AM, client #2 spooned Arginine (amino acid) independently into a glass once given a verbal prompt to do so.</p> <p>Client #2's record was reviewed on 8/11/15 at 2:22 PM. An ISP dated 8/27/14 included objectives to spoon her Arginine pills with one verbal prompt at 50% for three consecutive months, assist with preparing a side dish for a meal three times weekly in the PM with no</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G435	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4155 RAY ST INDIANAPOLIS, IN 46241
---	--

(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>more than 1 verbal prompt per step 70% of trials for three consecutive months, participate in a leisure activity with a peer for at least 10 minutes twice weekly in the PM independently within 100% of trials for three consecutive months, complete four steps of doing laundry at least one time weekly with no more than 1 verbal prompt per step 50% of trials for three consecutive months, sort coins at least three times weekly with assistance from staff with no more than 2 verbal prompts 100% of trials for three consecutive months, clean her room daily in PM with no more than 1 verbal prompt 70% of trials for three consecutive months, write and say the group home phone number two times weekly in the PM with no more than 2 verbal prompts 50% of trials for three consecutive months, complete all steps of tooth brushing at least daily in the AM and PM with no more than 1 verbal prompt 90% of trials for three consecutive months, and will wear her glasses daily in the PM with no more than 1 verbal prompt for 10% of trials for three consecutive months.</p> <p>A review by the QIDP for July, 2015 dated 8/9/15 of progress in client #2's objectives indicated the following:</p> <p>-100% progress to spoon her Arginine</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G435	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4155 RAY ST INDIANAPOLIS, IN 46241
---	--

(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>pills with 1 verbal prompt for 4/15, 5/15, 6/15 and 7/15.</p> <p>-100% progress to participate in a leisure activity with a peer for at least 10 minutes for 4/15, 5/15, 6/15 and 7/15.</p> <p>-complete steps of doing laundry once weekly for 50% of trials with 1 verbal prompt progress was met 50% for 4/15, 80% for 5/15, 80% for 6/15 and 60% for 7/15.</p> <p>-0% progress to sort coins at least three times weekly for 4/15, 5/15, 6/15 and 7/15.</p> <p>-90% progress for 4/15, 91% progress for 5/15, 80% progress for 6/15 and 78% progress for 7/15 for clean room daily in PM with one verbal prompt for 70% of trials.</p> <p>-0% progress for 4/15, 5/15, 6/15 and 7/15 to write and say the group home phone number for 50% of trials.</p> <p>-47% progress for 4/15, 100% for 5/15, 95% for 6/15 and 100% for 7/15 to complete all steps of toothbrushing at least daily.</p> <p>-100% for 4/15,5/15, 6/15 and 7/15 to wear her glasses daily for 10% of trials.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G435	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4155 RAY ST INDIANAPOLIS, IN 46241
---	--

(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>Recommendations indicated "Continue running objectives," and an Action Plan indicated "Continue meeting with HM to ensure all goals are being run correctly."</p> <p>3. Client #3's record was reviewed on 8/11/15 at 3:10 PM. Client #3's ISP dated 8/18/14 indicated objectives to tolerate taking morning/evening medications, wash arms with physical assistance, increase communication by using her communication book to identify wanted items, hand money to cashier, and tolerate having her teeth brushed.</p> <p>A review by the QIDP for July, 2015 dated 8/9/15 of progress in client #3's objectives indicated client #3 had met criteria for taking her medications washing her arms and tolerating having her teeth brushed. Client #3 had 0% success for 4 months to use her communication book to identify wanted items and handing money to cashier. Recommendations indicated "Continue running objectives," and an Action Plan indicated HM/PD to ensure goals are being run correctly.</p> <p>4. Client #4's record was reviewed on 8/13/15 at 3:35 PM. Client #4's ISP dated 12/2/14 indicated objectives to pop out his bedtime medications, wash his body</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G435	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4155 RAY ST INDIANAPOLIS, IN 46241
---	--

(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>with step by step verbal prompts, write/trace his name two times weekly, brush his teeth twice a day using an electric toothbrush, and wear his glasses in the PM.</p> <p>A review of client #4's objectives by the QIDP for July, 2015 dated 8/9/15 indicated client #4 had met criteria for popping out his medication, and wear glasses daily in the PM. Client #4 had 0% success for 4 months using his electric toothbrush. Recommendations indicated "Continue running objectives," and an Action Plan indicated "Continue to work towards [client #4] being more independent with his ADL's (adult daily living skills)."</p> <p>There was no evidence in any of the reviews that clients' objectives were being revised if met or if clients failed to make progress.</p> <p>The QIDP was interviewed on 8/13/15 at 4:00 PM and indicated clients' objectives should be revised when met or when they failed to make progress.</p> <p>9-3-3(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G435	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4155 RAY ST INDIANAPOLIS, IN 46241
---	--

(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
W 0186 Bldg. 00	<p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based upon observation, record review and interview, the facility failed to ensure there were adequate staff to meet the clients' needs for 4 of 4 sampled clients (clients #1, #2, #3 and #4), and 4 additional clients (clients #5, #6, #7 and #8).</p> <p>Findings include:</p> <p>Upon arrival at the group home on 8/10/15 at 7:20 PM until 7:55 PM, staff #4 was working alone in the group home and completed house cleaning chores. Clients #1, #2, #3, #4, #5, #6, #7, and #8 were in their beds asleep. Upon arrival, the surveyor indicated to staff #4 to call</p>	W 0186	<p>Program Director issued corrective action to the staff in the home that left on 8/10/15 without the notification to their direct manager and waiting for appropriate supervision to arrive to the home prior to leaving. Program Director will retrain all staff on providing effective active treatment throughout the day until the client chooses to go to bed at night. This will include following the clients Active Treatment schedules and providing active treatment during formal and informal activities. Staff will be retrained on the supervision levels of all clients in the home. Program Coordinator and Program Director will complete weekly active treatment</p>	09/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G435	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4155 RAY ST INDIANAPOLIS, IN 46241
---	--

(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 administrator to notify them of the survey being opened. Staff #4 then called the house manager.</p> <p>Staff #4 was interviewed on 8/10/15 at 7:35 PM and indicated she normally had another staff working with her, but the staff working with her had an emergency and left. She indicated the house manager was on her way in to work and when staff #4 was asked how long she had been working alone, stated, the "other staff left just before you came in."</p> <p>The house manager arrived at the group home at 7:55 PM, and indicated there are typically two staff working in the group home and stated staff leaving the home for the emergency and staff #4 "May have forgotten to call me. I didn't know." The HM indicated she would be staying to work in the group home until 10:00 PM as some of the clients had maladaptive behaviors and did not always remain asleep all night. She indicated clients #3 and #7 had a history of attempting elopement, and client #7 had a history of attempting to gain food and drink liquid cleaning products or toiletries. She indicated client #3 imitated client #7 and now attempted to grab at food.</p> <p>The client list provided for the home was reviewed on 8/11/15 at 12:30 PM</p>		<p>observations in the home to include a minimum of at least 4 routine observations as well as 4 pop-up observations at varied times to ensure adequate supervision as well as continuous effective active treatment is provided to the consumers. Responsible Party: Program Director, Program Coordinator</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G435	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4155 RAY ST INDIANAPOLIS, IN 46241
---	--

(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>indicated there were two staff scheduled on second shift in the home.</p> <p>Client #1's record was reviewed on 8/11/15 at 1:25 PM. An ISP (Individual Support Plan) dated 8/30/14 indicated she had dementia and required staff assistance for dressing, personal hygiene, eating and the use of a gait belt to assist in ambulation. Client #1 had a history of falls. Client #1's BSP (Behavior Support Plan) dated 8/30/14 indicated a target behavior of self injurious behavior.</p> <p>Client #2's record was reviewed on 8/11/15 at 2:22 PM. An ISP dated 8/27/14 indicated she required assistance to shower, complete personal hygiene tasks, and used a walker for unsteady gait.</p> <p>Client #3's record was reviewed on 8/11/15 at 3:10 PM. An ISP dated 8/18/14 indicated she had limited communication skills, required staff assistance to complete personal hygiene tasks. Client #3 had a history of seizures.</p> <p>Client #4's record was reviewed on 8/13/15 at 3:35 PM. An ISP dated 12/2/14 indicated he had a diagnosis of depression with physical aggression, and required assistance with personal hygiene and showering.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G435	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4155 RAY ST INDIANAPOLIS, IN 46241
---	--

(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
W 0249 Bldg. 00	<p>Client #7's record was reviewed on 8/13/15 at 4:10 PM. There was no evidence of a BSP in the record. Client #7's ISP dated 3/9/15 indicated she required assistance to complete personal hygiene and showering.</p> <p>Client #7's BSP dated 3/11/15 was reviewed on 8/13/15 at 6:00 PM and indicated target objectives of dropping to the ground and eating unauthorized food.</p> <p>The PD (Program Director) was interviewed on 8/14/15 at 11:00 AM and indicated there should have been two staff on duty on 8/10/15 at 7:20 PM and the issue was being addressed.</p> <p>9-3-3(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G435	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4155 RAY ST INDIANAPOLIS, IN 46241
---	--

(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>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 upon observation, record review and interview, the facility failed to ensure implementation of 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 1 additional client (client #7) ISP (Individual Support Plan) objectives and active treatment schedules during formal and informal opportunities.</p> <p>Findings include:</p> <p>Upon arrival at the group home on 8/10/15 at 7:20 PM until 7:55 PM, staff #4 was working alone in the group home and completed house cleaning chores. Clients #1, #2, #3, #4, #5, #6, #7, and #8 were in their beds asleep. During observations on 8/11/15 from 6:15 AM until 8:30 AM and again on 8/11/15 from 4:20 PM until 5:30 PM, client #7 was not prompted to engage in activity. Client #3 was prompted to set the table during the observation on 8/11/15 from 4:20 PM until 5:30 PM, but was not prompted to engage in other activity or to use her communication book. Client #1 was not prompted to engage in a leisure activity during the</p>	W 0249	<p>Program Director will retrain all staff on providing effective active treatment throughout the day until the client chooses to go to bed at night. This will include following the clients Active Treatment schedules, goals and objectives schedules and providing active treatment during formal and informal activities. This will include inclusion in mealtime and household chores. Program Coordinator and Program Director will completeweekly active treatment observations in the home to include a minimum of atleast 4 routine observations as well as 4 pop-up observations at varied timesto ensure adequate supervision as well as continuous effective active treatmentis provided to the consumers. Responsible Party: Program Director, Program Coordinator</p>	09/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G435	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4155 RAY ST INDIANAPOLIS, IN 46241
---	--

(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>observations and client #4 was not prompted to write/trace his name. Client #2 was not prompted to sort coins, complete laundry tasks, clean her room or write/say the group home phone number during the observations.</p> <p>1. Client #1's record was reviewed on 8/11/15 at 1:25 PM. Client #1's ISP dated 8/30/14 indicated objectives to spoon medications into her mouth with no more than 3 verbal prompts at 10% of trials attempted for three consecutive months, brush her teeth with hand over hand assistance with one physical prompt with 10% for three consecutive months, eat at least 4-5 bites with physical prompts at 50% for three consecutive months, participate in a leisure activity with a peer twice weekly in the PM independently in 100% of trials for three consecutive months, participate in community activities with staff monitoring at least once weekly in the PM with no more than 1 physical prompt, 100% of trials for three consecutive months, rub body with soap in the shower daily with no more than 1 physical prompts at 100% of trials for three consecutive months, make a purchase in the community twice weekly with assistance from staff with 1 physical prompt 50% of trials for three consecutive months.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G435	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4155 RAY ST INDIANAPOLIS, IN 46241
---	--

(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's Active Treatment Schedule (undated) in the record indicated she was to participate in ADL (Adult Daily Living) skills/unstructured activity at 7:00 PM and prepare for bed, receive medications and PM hygiene at 8:00 PM.</p> <p>2. Client #2's record was reviewed on 8/11/15 at 2:22 PM. An ISP dated 8/27/14 included objectives to complete four steps of doing laundry at least one time weekly with no more than 1 verbal prompt per step 50% of trials for three consecutive months, sort coins at least three times weekly with assistance from staff with no more than 2 verbal prompts 100% of trials for three consecutive months, clean her room daily in PM with no more than 1 verbal prompt 70% of trials for three consecutive months, write and say the group home phone number two times weekly in the PM with no more than 2 verbal prompts 50% of trials for three consecutive months, complete all steps of tooth brushing at least daily in the AM and PM with no more than 1 verbal prompt 90% of trials for three consecutive months, will wear her glasses daily in the PM with no more than 1 verbal prompt for 10% of trials for three consecutive months.</p> <p>Client #2's Active Treatment Schedule (undated) in the record indicated she was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G435	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4155 RAY ST INDIANAPOLIS, IN 46241
---	--

(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>to participate in ADL (Adult Daily Living) skills/unstructured activity at 7:00 PM and prepare for bed at 8:00 PM.</p> <p>3. Client #3's record was reviewed on 8/11/15 at 3:10 PM. Client #3's ISP dated 8/18/14 indicated objectives to tolerate taking morning/evening medications, wash arms with physical assistance, increase communication by using her communication book to identify wanted items, hand money to cashier, and tolerate having her teeth brushed.</p> <p>Client #3's Active Treatment Schedule (undated) in the record indicated she was to participate in ADL (Adult Daily Living) skills/unstructured activity at 7:00 PM and prepare for bed at 8:00 PM.</p> <p>4. Client #4's record was reviewed on 8/13/15 at 3:35 PM. Client #4's ISP dated 12/2/14 indicated objectives to pop out his bedtime medications, wash his body with step by step verbal prompts, write/trace his name two times weekly, brush his teeth twice a day using an electric toothbrush, and wear his glasses in the PM.</p> <p>Client #4's Active Treatment Schedule (undated) in the record indicated he was to participate in ADL (Adult Daily Living) skills/unstructured activity at</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G435		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2015	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 4155 RAY ST INDIANAPOLIS, IN 46241			
(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>7:00 PM and prepare for bed at 8:00 PM.</p> <p>5. Client #7's record was reviewed on 8/13/15 at 4:10 PM. An ISP dated 3/19/15 indicated objectives to spoon medications into her mouth, wash hands after using the bathroom, retrieve change from the cashier, and stay out of housemates' bedrooms.</p> <p>The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 8/11/15 at 3:16 PM and indicated the clients should not have been asleep at 7:20 PM on 8/10/15 and their active treatment schedules and objectives should have been implemented. She indicated clients' goals and objectives should be implemented.</p> <p>9-3-4(a)</p>						
W 0250 Bldg. 00	<p>483.440(d)(2) PROGRAM IMPLEMENTATION</p> <p>The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.</p> <p>Based upon record review and interview, facility failed for 1 of 4 sampled clients</p>	W 0250	Area Director will retrain Program Director on updating clients Active Treatment schedule annually and	09/20/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G435	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2015
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 4155 RAY ST INDIANAPOLIS, IN 46241		
(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), to update her active treatment schedule as needed.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 8/11/15 at 1:25 PM. A review by the QIDP (Qualified Intellectual Disabilities Professional) for July, 2015 dated 8/9/15 of progress in client #1's objectives indicated she attended day services one to two times weekly.</p> <p>Client #1's Active Treatment Schedule (undated) in the record indicated she was to attend day services Monday through Friday from 10:00 AM until 2:00 PM.</p> <p>The QIDP was reviewed on 8/11/15 at 4:00 PM and indicated client #1's schedule needed to be updated to reflect her current status.</p> <p>9-3-4(a)</p>		<p>as schedules require amendments-including date of schedule update.</p> <p>Program Director will update the Active Treatment Schedule for client #1 and review and update all clients' Active treatment in the home for any others identified.</p> <p>Program Director will update consumers' active treatment schedule annually in conjunction with clients IDT meeting and ISP update.</p> <p>Responsible Party: Area Director, Program Director</p>		