

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 03/26/2014
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	
W000000	<p>This visit was for the investigation of complaint #IN00145928.</p> <p>Complaint #IN00145928: Unsubstantiated, due to lack of sufficient evidence.</p> <p>Unrelated deficiencies cited.</p> <p>Survey Dates: March 24, 25 and 26, 2014</p> <p>Facility Number: 000924 Provider Number: 15G410 AIM Number: 100244510</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 3/28/14 by Ruth Shackelford, QIDP.</p>	W000000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W000149	<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 10 incident/investigative reports reviewed affecting clients A, C, D and H, the facility neglected to implement their policies and procedures for reporting an allegation of abuse to the administrator immediately, reporting an allegation of abuse to the Bureau of Developmental Disabilities Services (BDDS) timely, and neglected to conduct thorough investigations of client abuse and the death of client H.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 3/24/14 at 1:23 PM and indicated the following:</p> <p>1) On 12/30/13, client H was visiting her family over the holidays. The home client H was staying in caught on fire and client H was unable to escape the fire resulting in client H's death. The investigation, dated 1/6/14, indicated client H was picked up on 12/24/13 by her brother and was to return in early January 2014. On 12/30/13, the Area Director (AD) received a phone call</p>	W000149	The Quality Assurance Specialist was retrained on Investigation Procedures/Timelines on 2/18/14. The Program Director was retrained on Completing required investigations for incidents and Timeliness of reporting BDDS reports on 4/11/14. Staff in the home were retrained on preventing abuse/neglect and reporting incidents timely to a supervisor on 1/31/14. Corrective action will be completed as needed for any late reporting of incidents. The Program Director will meet with the Area Director weekly to review all incidents to ensure timeliness of reportable incidents and to review incidents to determine whether an investigation should be completed. The Area Director will review incidents and investigations for timeliness. Corrective action will be completed as needed for any concerns related to these topics. Responsible Party: Program Director, Area Director	04/25/2014			

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	<p>between 10:00 PM and 10:15 PM from the Program Director (PD) reporting that the Home Manager (HM) had just received a phone call from client H's sister indicating client H had died in a fire at her mother's home that evening. The report indicated the HM reported client H's sister told her that her other sister and mother were at home with client H at the time of the fire. The HM reported no one knew the cause of the fire. The Conclusion of the investigation indicated, "Per a report from [client H's] sister, [name of sister], [client H] passed away on 12/30/13 due to being unable to escape a house fire at her family's home while on a holiday visit." The facility did not obtain a police or fire department report, death certificate or interview family members to obtain additional information regarding client H's death.</p> <p>On 3/25/14 at 1:07 PM, the Area Director (AD) indicated the investigation was not thorough. The AD indicated the facility did not obtain a copy of the death certificate or the police/fire department report. The AD indicated he spoke to client H's brother however the interview with the brother was not included in the investigation. The AD indicated the fire was centered in the area where client H's bedroom was located. The AD indicated when the family members went in to get</p>			

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	<p>client H, she was on fire. The AD indicated client H's sister thought client H was smoking at the time. The AD indicated client H was not supposed to light her own cigarettes.</p> <p>2) On 1/9/14, allegations were brought to the HM's attention that on 1/8/14 at 7:30 PM, two staff emotionally abused client A. Client A reported staff yelled, screamed and tried to set her up by putting food in her room while she was busy doing something else. Client A indicated when she went into her room, she found food sitting on the nightstand. The investigation, dated 1/13/14, indicated, in part, "The allegation was made by [client A] against DSPs (Direct Support Professionals), [staff #8] and [staff #13]. [Client A] stated that at approx 8 pm on 1/8/14, when she was heading to bed, she was made (by [staff #8]) to go wash laundry for clean clothes to wear to a funeral the following day. After loading laundry, [client A] proceeded to go back to bed and found 2 pork chops lying on her bedside table. [Client A] reported this to [name of Home Manager] on 1/9/14. After she found the pork chops, she took them and threw them away in the bathroom trash. After this, [client A] said [staff #13] came in and asked where the pork chops were and [client A] told her she threw</p>			
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	<p>them away. [Staff #13] and [staff #8] made [client A] take the pork chops out of the bathroom trash and put it in the kitchen trash and was made to take it out to trash can outside of the home. [Client A] also stated that both staff verbally abused her and yelled at her. [Client A] stated that [staff #8] and [staff #13] accused her of placing the pork chops there herself but that she did not do it and told them she believed they had done it. There are also allegations of yelling and screaming at her from these two staff." An interview with staff #4 included in the investigation indicated, in part, "...[Staff #4] was also asked if anything unusual happened that night and [staff #4] explained '[staff #13] told me, 'Me and [staff #8] put a pork chop in [client A's] room.' [Staff #4] said that [staff #13] told her this after [client A] had already gone to bed. [Staff #4] (was) asked why she didn't report what [staff #13] said and [staff #4] said she thought [staff #13] was 'just joking' and [client A] didn't report anything to her that anything had happened with any pork chops. [Staff #4] was asked about what time this incident occurred and [staff #4] replied '7:30-8 PM, whenever [client A] goes to bed.' [Staff #4] went on to say '[client A] went back to her room after doing her laundry, then went to the bathroom, and [staff #8] said in a stern voice 'what's taking you so</p>			
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	<p>long in the bathroom?' [Staff #4] said, '[Client A] replied 'I am going to the bathroom.' [Staff #4] also said 'while [client A] was in bathroom, [staff #13] told [staff #8] to go look in [client A's] room' but at the time, [staff #4] said she didn't know why [staff #13] told [staff #8] to go look. When [client A] went back to bed, '[staff #13] went back into the bedroom and talked to [client A] in mean tone' but [staff #4] didn't know what she said to [client A] and just heard the tone of her voice escalate but [client A] didn't report anything about this to her either. When asked if she had any sort of conversation with [staff #8] regarding any of this incident, her reply was 'none at all.' [Staff #4] also stated that '[staff #8] was laughing a lot, and there were a lot whispers and laughing between the two of them' during the shift that evening, but she didn't know what they were laughing about." The Conclusion of the investigation indicated, "There is not enough evidence to support who put the pork chops in [client A's] bedroom." The investigation did not indicate whether or not the allegation of verbal and emotional abuse was substantiated. Staff #4 did not immediately report the incident to the administrator.</p> <p>On 3/24/14 at 4:19 PM, staff #4 indicated staff #8 and #13 were making fun of</p>			
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	<p>client A at the time of the incident. Staff #4 indicated staff #13 told her that staff #13 put a pork chop in client A's room. Staff #4 indicated at the time of the incident she was not aware of what was going on. Staff #4 indicated staff #8 and #13 were laughing and joking. Staff #4 indicated when staff #13 told her she put a pork chop in client A's room, she thought the staff was joking. Staff #4 indicated she did not see the pork chop in the room or know, at the time, what happened. Staff #4 indicated she should have reported the incident immediately when staff #13 told her what she did.</p> <p>On 3/25/14 at 1:27 PM, the AD indicated the facility unsubstantiated the allegation of emotional and verbal abuse. The AD stated staff #4 was "iffy" on her statements. The AD indicated be believed staff #4 had misconstrued what was said by staff #8 and #13. The AD indicated staff #4 did not immediately report the incident due to believing the staff were joking. The AD indicated staff #4 should have immediately reported the incident to the administrator. The AD indicated the investigation did not address the verbal abuse. The AD indicated the investigation should indicate whether or not the allegation was substantiated. The AD indicated there was a policy/procedure prohibiting abuse</p>						

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	<p>of the clients. The AD indicated the facility should prevent abuse of the clients.</p> <p>3) On 1/22/14 (reported to BDDS on 1/24/14) at 3:00 PM, client A asked to sit in the front seat of the van. Staff told client A "no" because it was a rule no one could sit in front if all the clients were together in the van. Client A cussed and threw her lunch box and bumped another client (did not indicate the client) out of her way. The facility did not conduct an investigation of client to client abuse.</p> <p>On 3/25/14 at 1:27 PM, the AD indicated client to client aggression was considered abuse and should be investigated. The AD indicated there was a policy/procedure prohibiting abuse of the clients. The AD indicated the facility should prevent abuse of the clients. The AD indicated the timeframe for submitting reports to BDDS was 24 hours.</p> <p>4) On 2/3/14 at 4:30 PM, client D slammed her cup of soda and it went all over the table and dining room. Client A came over and made a statement regarding the incident. Client D "swatted" client A with an open hand on the upper arm. The facility did not conduct an investigation of client to client</p>			

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	<p>abuse.</p> <p>On 3/25/14 at 1:27 PM, the AD indicated client to client aggression was considered abuse and should be investigated. The AD indicated there was a policy/procedure prohibiting abuse of the clients. The AD indicated the facility should prevent abuse of the clients.</p> <p>5) On 2/26/14 at 11:40 AM at the facility-operated day program, client D was listening to the radio when client C walked over and unplugged the radio. Client D told client C to stop and "grabbed [client C] by the arm." Client C then "pushed" client D away. The facility did not conduct an investigation of client to client abuse.</p> <p>On 3/25/14 at 1:27 PM, the AD indicated client to client aggression was considered abuse and should be investigated. The AD indicated there was a policy/procedure prohibiting abuse of the clients. The AD indicated the facility should prevent abuse of the clients.</p> <p>A review of the facility's abuse and neglect policy, dated April 2011, was conducted on 3/24/14 at 1:09 PM. The policy indicated the following, "Any allegation of abuse or human rights violation is thoroughly investigated by</p>						

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	<p>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." The policy indicated, "Indiana MENTOR is committed to completing a thorough investigation for any event out of the ordinary which jeopardizes the health and safety of any individual served or other employee." The policy indicated, in part, "Indiana MENTOR follows the BDDS Incident Reporting policy as outlined in the Provider Standards. An incident described as follows shall be reported to the BDDS on the incident report form prescribed by the BDDS... A fall resulting in injury, regardless of severity of injury." The policy indicated, in part, "An initial report regarding an incident shall be submitted within twenty-four (24) hours</p>				

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	of: a) the occurrence of the incident; or b) the reporter becoming aware of or receiving information about an incident." 9-3-2(a)			

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W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 2 of 10 incident/investigative reports reviewed affecting client A, the facility failed to report an allegation of abuse to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law and failed to ensure staff immediately reported an allegation of abuse to the administrator.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 3/24/14 at 1:23 PM and indicated the following:</p> <p>1) On 1/22/14 (reported to BDDS on 1/24/14) at 3:00 PM, client A asked to sit in the front seat of the van. Staff told client A "no" because it was a rule no one could sit in front if all the clients were together in the van. Client A cussed and threw her lunch box and bumped another client (did not indicate the client) out of her way.</p>	W000153	<p>The Program Director was retrained on Completing required investigations for incidents and Timeliness of reporting BDDS reports on 4/11/14. The Program Director will meet with the Area Director weekly to review all incidents to ensure timeliness of reportable incidents and to review incidents to determine whether an investigation should be completed. The Area Director will review incidents and investigations for timeliness. Corrective action will be completed as needed for any concerns related to these topics. Responsible Party: Program Director, Area Director</p>	04/25/2014
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	<p>On 3/25/14 at 1:27 PM, the AD indicated the timeframe for submitting reports to BDDS was 24 hours.</p> <p>2) On 1/9/14, allegations were brought to the HM's attention that on 1/8/14 at 7:30 PM, two staff emotionally abused client A. Client A reported staff yelled, screamed and tried to set her up by putting food in her room while she was busy doing something else. Client A indicated when she went into her room, she found food sitting on the nightstand. The investigation, dated 1/13/14, indicated, in part, "DSP's (Direct Support Professionals) [staff #8] and [staff #13] were immediately suspended upon investigation on 1/9/14. [Staff #4] was suspended on 1/9/14 for possible late reporting."</p> <p>On 3/24/14 at 4:19 PM, staff #4 indicated she should have reported the incident immediately when staff #13 told staff #4 what staff #13 did (put the pork chop in client A's bedroom).</p> <p>On 3/25/14 at 1:27 PM, the AD indicated staff #4 should have immediately reported the incident to the administrator.</p> <p>9-3-2(a)</p>			

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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 5 of 10 incident/investigative reports reviewed affecting clients A, C, D and H, the facility failed to conduct thorough investigations of client abuse and the death of client H.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 3/24/14 at 1:23 PM and indicated the following:</p> <p>1) On 12/30/13, client H was visiting her family over the holidays. The home client H was staying in caught on fire and client H was unable to escape the fire resulting in client H's death. The investigation, dated 1/6/14, indicated client H was picked up on 12/24/13 by her brother and was to return in early January 2014. On 12/30/13, the Area Director (AD) received a phone call between 10:00 PM and 10:15 PM from the Program Director (PD) reporting that the Home Manager (HM) had just received a phone call from client H's sister stating client H had died in a fire at her mother's home that evening. The</p>	W000154	<p>The Quality Assurance Specialist was retrained on Investigation Procedures/Timelines on 2/18/14. The Program Director was retrained on Completing required investigations for incidents and Timeliness of reporting BDDS reports on 4/11/14. The Program Director will meet with the Area Director weekly to review all incidents to ensure timeliness of reportable incidents and to review incidents to determine whether an investigation should be completed. The Area Director will review incidents and investigations for timeliness. Corrective action will be completed as needed for any concerns related to these topics. Responsible Party: Program Director, Area Director</p>	04/25/2014			

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	<p>report indicated the HM reported client H's sister told her that her other sister and mother were at home with client H at the time of the fire. The HM reported no one knew the cause of the fire. The Conclusion of the investigation indicated, "Per a report from [client H's] sister, [name of sister], [client H] passed away on 12/30/13 due to being unable to escape a house fire at her family's home while on a holiday visit." The facility did not obtain a police or fire department report, death certificate or interview family members to obtain additional information regarding client H's death.</p> <p>On 3/25/14 at 1:07 PM, the Area Director (AD) indicated the investigation was not thorough. The AD indicated the facility did not obtain a copy of the death certificate or the police/fire department report. The AD indicated he spoke to client H's brother however the interview with the brother was not included in the investigation. The AD indicated the fire was centered in the area where client H's bedroom was located. The AD indicated when the family members went in to get client H, she was on fire. The AD indicated client H's sister thought client H was smoking at the time. The AD indicated client H was not supposed to light her own cigarettes.</p>				

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	<p>2) On 1/9/14, allegations were brought to the HM's attention that on 1/8/14 at 7:30 PM, two staff emotionally abused client A. Client A reported staff yelled, screamed and tried to set her up by putting food in her room while she was busy doing something else. Client A indicated when she went into her room, she found food sitting on the nightstand. The investigation, dated 1/13/14, indicated, in part, "The allegation was made by [client A] against DSPs (Direct Support Professionals), [staff #8] and [staff #13]. [Client A] stated that at approx 8 pm on 1/8/14, when she was heading to bed, she was made (by [staff #8]) to go wash laundry for clean clothes to wear to a funeral the following day. After loading laundry, [client A] proceeded to go back to bed and found 2 pork chops lying on her bedside table. [Client A] reported this to [name of Home Manager] on 1/9/14. After she found the pork chops, she took them and threw them away in the bathroom trash. After this, [client A] said [staff #13] came in and asked where the pork chops were and [client A] told her she threw them away. [Staff #13] and [staff #8] made [client A] take the pork chops out of the bathroom trash and put it in the kitchen trash and was made to take it out to trash can outside of the home. [Client A] also stated that both staff verbally</p>						

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	<p>abused her and yelled at her. [Client A] stated that [staff #8] and [staff #13] accused her of placing the pork chops there herself but that she did not do it and told them she believed they had done it. There are also allegations of yelling and screaming at her from these two staff." An interview with staff #4 included in the investigation indicated, in part, "...[Staff #4] was also asked if anything unusual happened that night and [staff #4] explained '[staff #13] told me, 'Me and [staff #8] put a pork chop in [client A's] room.' [Staff #4] said that [staff #13] told her this after [client A] had already gone to bed. [Staff #4] (was) asked why she didn't report what [staff #13] said and [staff #4] said she thought [staff #13] was 'just joking' and [client A] didn't report anything to her that anything had happened with any pork chops. [Staff #4] was asked about what time this incident occurred and [staff #4] replied '7:30-8 PM, whenever [client A] goes to bed.' [Staff #4] went on to say '[client A] went back to her room after doing her laundry, then went to the bathroom, and [staff #8] said in a stern voice 'what's taking you so long in the bathroom?' [Staff #4] said, '[Client A] replied 'I am going to the bathroom.' [Staff #4] also said 'while [client A] was in bathroom, [staff #13] told [staff #8] to go look in [client A's] room' but at the time, [staff #4] said she</p>			
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	<p>didn't know why [staff #13] told [staff #8] to go look. When [client A] went back to bed, '[staff #13] went back into the bedroom and talked to [client A] in mean tone' but [staff #4] didn't know what she said to [client A] and just heard the tone of her voice escalate but [client A] didn't report anything about this to her either. When asked if she had any sort of conversation with [staff #8] regarding any of this incident, her reply was 'none at all.' [Staff #4] also stated that '[staff #8] was laughing a lot, and there were a lot whispers and laughing between the two of them' during the shift that evening, but she didn't know what they were laughing about." The Conclusion of the investigation indicated, "There is not enough evidence to support who put the pork chops in [client A's] bedroom." The investigation did not indicate whether or not the allegation of verbal and emotional abuse was substantiated. Staff #4 did not immediately report the incident to the administrator.</p> <p>On 3/24/14 at 4:19 PM, staff #4 indicated staff #8 and #13 were making fun of client A at the time of the incident. Staff #4 indicated staff #13 told her that staff #13 put a pork chop in client A's room. Staff #4 indicated at the time of the incident she was not aware of what was going on. Staff #4 indicated staff #8 and</p>			
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	<p>#13 were laughing and joking. Staff #4 indicated when staff #13 told her she put a pork chop in client A's room, she thought the staff was joking. Staff #4 indicated she did not see the pork chop in the room or know, at the time, what happened. Staff #4 indicated she should have reported the incident immediately when staff #13 told her what she did.</p> <p>On 3/25/14 at 1:27 PM, the AD indicated the facility unsubstantiated the allegation of emotional and verbal abuse. The AD stated staff #4 was "iffy" on her statements. The AD indicated be believed staff #4 had misconstrued what was said by staff #8 and #13. The AD indicated staff #4 did not immediately report the incident due to believing the staff were joking. The AD indicated the investigation did not address the verbal abuse. The AD indicated the investigation should indicate whether or not the allegation was substantiated.</p> <p>3) On 1/22/14 at 3:00 PM, client A asked to sit in the front seat of the van. Staff told client A "no" because it was a rule no one could sit in front if all the clients were together in the van. Client A cussed and threw her lunch box and bumped another client (did not indicate the client) out of her way. The facility did not conduct an investigation of client to client</p>						

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	<p>abuse.</p> <p>On 3/25/14 at 1:27 PM, the AD indicated client to client aggression was considered abuse and should be investigated.</p> <p>4) On 2/3/14 at 4:30 PM, client D slammed her cup of soda and it went all over the table and dining room. Client A came over and made a statement regarding the incident. Client D "swatted" client A with an open hand on the upper arm. The facility did not conduct an investigation of client to client abuse.</p> <p>On 3/25/14 at 1:27 PM, the AD indicated client to client aggression was considered abuse and should be investigated.</p> <p>5) On 2/26/14 at 11:40 AM at the facility-operated day program, client D was listening to the radio when client C walked over and unplugged the radio. Client D told client C to stop and "grabbed [client C] by the arm." Client C then "pushed" client D away. The facility did not conduct an investigation of client to client abuse.</p> <p>On 3/25/14 at 1:27 PM, the AD indicated client to client aggression was considered abuse and should be investigated.</p>			

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W000203	<p>483.440(b)(5)(i) ADMISSIONS, TRANSFERS, DISCHARGE At the time of the discharge the facility must develop a final summary of the client's developmental, behavioral, social, health and nutritional status.</p> <p>Based on record review and interview for 1 of 1 client who was discharged from the facility (E), the facility failed to develop a final summary of the client's developmental, behavioral, social, health and nutritional status.</p> <p>Findings include:</p> <p>A review of client E's record was conducted on 3/25/14 at 12:10 PM. The facility did not have documentation indicating a discharge summary was completed at the time of client E's discharge on 11/12/13. Client E was discharged to a nursing home.</p> <p>On 3/25/14 at 1:07 PM, the Area Director (AD) indicated he was unable to locate the documentation of the facility's discharge summary for client E. The AD indicated the Program Director was on vacation and the facility was attempting to retrieve the information from her computer. The AD indicated a discharge summary should have been completed.</p> <p>9-3-4(a)</p>	W000203	<p>Program and Medical Discharge Summaries were completed for Client E upon his discharge in November 2013. The Program discharge form was not printed and available for review at the time of the survey. It was reviewed with the Program Director to submit the form to the administrator for review and to print the form to be included with the client's program record. Responsible Party: Program Director, Area Director</p>	04/25/2014	

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