

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G763	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2024
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC		STREET ADDRESS, CITY, STATE, ZIP COD 114 S CHESTNUT ST HUNTINGBURG, IN 47542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 the pre-determined full recertification and state licensure survey.</p> <p>Dates of Survey: 7/8/24, 7/9/24, 7/10/24, 7/11/24 and 7/12/24.</p> <p>Facility Number: 012289 Provider Number: 15G763 AIMS Number: 100249380</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 7/17/24.</p>	W 0000		
W 0159 Bldg. 00	<p>483.430(a) QIDP</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who-</p> <p>Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3), the QIDP (Qualified Intellectual Disabilities Professional) failed to integrate, coordinate and monitor clients #1, #2 and #3's program plans. The QIDP failed to: 1) monitor regression or progress of clients #1, #2 and #3's program goals and 2) ensure behavioral data was collected for targeted behaviors in clients #1, #2 and #3 BSPs (Behavioral Support Plans).</p> <p>Findings include:</p> <p>1A. Client #1's record was reviewed on 7/9/24 at 11:08 AM.</p>	W 0159	<p>Program Directors will be trained on ensuring all documentation is completed in the home including goals and behavior tracking</p> <p>Program Directors will be trained on QIDP responsibilities including updating all plans when needed</p> <p>All staff will be trained on individuals' plans including all ISPs and BSPs</p> <p>All staff will be trained on documentation</p> <p>Program Supervisor will monitor at least three times</p>	08/11/2024

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

TITLE

(X6) DATE

Bret Beauchamp

Regional Director

07/29/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosed 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G763	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2024
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC		STREET ADDRESS, CITY, STATE, ZIP COD 114 S CHESTNUT ST HUNTINGBURG, IN 47542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 action plan summary, dated 6/1/24, indicated the following goals:</p> <p>"...[Client #1] will weekly hang up and fold his laundry...</p> <p>[Client #1] will interact with peers for 1 hour...</p> <p>[Client #1] will clean his room and bedding...</p> <p>[Client #1] will respect the personal boundaries of others...</p> <p>[Client #1] will count his AM pills...</p> <p>[Client #1] will stay with the group out in the community...</p> <p>[Client #1] will wash thoroughly in the shower...."</p> <p>Documentation of goal monitoring for client #1's goals was not available for review from 7/1/2023 to 6/18/24.</p> <p>1B. Client #2's record was reviewed on 7/9/24 at 12:38 PM.</p> <p>Client #2's action plan summary, dated 6/1/24, indicated the following goals:</p> <p>"...[Client #2] will work on taking belongings from her peers daily...</p> <p>[Client #2] will weekly complete her laundry and fold and hang her clothes up promptly...</p> <p>[Client #2] will respect the personal boundaries of her peers daily...</p> <p>[Client #2] will stay with the staff when shopping...</p> <p>Weekly [client #2] will clean her room and change her bedding...</p> <p>[Client #2] will wash her hair...."</p> <p>Documentation of goal monitoring for client #2's goals was not available for review from 7/1/23 to 7/1/24.</p> <p>1C. Client #3's record was reviewed on 7/9/24 at 1:24 PM.</p>		<p>weekly during home visits Program Director will monitor at least once weekly during Site Supervisor Visits</p> <p>Persons Responsible: Area Director, Program Director, Program Supervisor</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G763	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2024
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC		STREET ADDRESS, CITY, STATE, ZIP COD 114 S CHESTNUT ST HUNTINGBURG, IN 47542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0252 Bldg. 00	<p>Client #3's action plan summary, dated 6/1/24, indicated the following goals:</p> <p>"...[Client #3] will choose an item to purchase at the store...</p> <p>[Client #3] will 1 time weekly put his laundry in the washer...</p> <p>[Client #3] will daily after dinner take his plate into the kitchen...</p> <p>[Client #3] will 1 time weekly practice sign language with staff...."</p> <p>Documentation of goal monitoring for client #3's goals was not available for review from 7/1/23 to 6/17/24.</p> <p>The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 7/10/24 at 10:15 AM. The QIDP indicated goals should be monitored monthly. The QIDP indicated she is new with the facility and the previous QIDP did not leave any documentation to show goals were monitored. The QIDP indicated she runs a report and reviews the data quarterly with the team. The QIDP indicated the team talks about the goals and how the client was doing based on data to determine if the goals need to be revised.</p> <p>2. Please see W252. The QIDP failed to collect behavior data for clients #1, #2 and #3's targeted behaviors.</p> <p>9-3-3(a)</p> <p>483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G763	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2024
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC		STREET ADDRESS, CITY, STATE, ZIP COD 114 S CHESTNUT ST HUNTINGBURG, IN 47542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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>Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3), the facility failed to ensure behavioral data was collected for targeted behaviors in clients #1, #2 and #3's BSPs (Behavioral Support Plans).</p> <p>Findings include:</p> <p>A. Client #1's record was reviewed on 7/9/24 at 11:08 AM.</p> <p>Client #1's BSP dated 4/1/24 indicated the following:</p> <p>"...Targeted Behavior 1- Socially Offensive Behavior is defined as, but not limited to, standing too close to others, touching others without permission...</p> <p>Targeted Behavior 2-Inadequate Personal Hygiene is defined as, but not limited to, failure to properly care for his glasses...</p> <p>Targeted Behavior 3- Inappropriate phone/Internet usage is defined as, but not limited to, watching pornography in common areas, and inappropriate conversations with parent resulting in yelling, crying, or becoming agitated...</p> <p>A medication reduction of Lamotrigine 200 mg (bi-polar) will be presented to prescribing doctor after 6 months with (sic) 5 incidents of socially offensive behavior...."</p> <p>Behavior data was not available for review from 6/1/23 to 7/1/24.</p> <p>B. Client #2's record was reviewed on 7/9/24 at 12:38 PM.</p> <p>Client #2's BSP dated 4/1/24 indicated the following:</p> <p>"...Targeted Behavior 1- Aggression towards self is defined as, but not limited to, hitting/slapping</p>	W 0252	<p>Area Director and Program Directors will be trained on ensuring all documentation is completed in the homes</p> <p>All staff will be trained on documentation including objectives, behavior plans, and daily notes</p> <p>Program Director will monitor at least once weekly during weekly Site Supervisory visits</p> <p>Program Supervisor will monitor at least three times weekly during home visits</p> <p>Persons Responsible: Area Director, Program Director, Program Supervisor</p>	08/11/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G763	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2024
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC		STREET ADDRESS, CITY, STATE, ZIP COD 114 S CHESTNUT ST HUNTINGBURG, IN 47542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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>self and bending thumb back as far as it will go... Targeted Behavior 2- Disruptive behavior defined as, but not limited to, screaming, yelling, making excessive noise, bothering others, starting arguments, interrupting others, and excessive attention seeking...</p> <p>Targeted Behavior 3-Uncooperative Behavior is defined as, but not limited to, refusing to follow directions, refusing to perform chores, refusing to follow rules, and acting defiant...</p> <p>Targeted Behavior 4- Untrustworthy Behavior is defined as, but not limited to, taking others' possessions, throwing away or hoarding stolen items-especially in her closet, lying, and making false allegation against staff...</p> <p>Targeted Behavior 5- Inappropriate Toileting is defined as, but not limited to, failure to adequately clean up after herself following a BM (bowel movement)...</p> <p>The medication reduction of Paxil 40 mg (anti-depressant/obsessive behavior) will be presented to the prescribing doctor after 6 months with 5 or less incidents of aggression towards self...."</p> <p>Behavior data was not available for review from 6/1/23 to 7/1/24.</p> <p>C. Client #3's record was reviewed on 7/9/24 at 1:24 PM.</p> <p>Client #3's BSP dated 4/1/24 indicated the following:</p> <p>"...Target Behavior 1. Aggression towards self is defined as, but not limited to, hit/slap (sic) his own face, head or body...</p> <p>Target Behavior 2. Inappropriate Eating Behavior is defined as, but not limited to, eating too much, food seeking, and taking food from garbage...</p> <p>The medication reduction of Lamictal 200 mg</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G763	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2024
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC		STREET ADDRESS, CITY, STATE, ZIP COD 114 S CHESTNUT ST HUNTINGBURG, IN 47542		
(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 0368 Bldg. 00	<p>(mood stabilizer) will be presented to [doctor] after 6 months with 5 incidents or less aggression towards self...."</p> <p>Behavior data was not available for review from 6/1/23 to 7/1/24.</p> <p>The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 7/10/24 at 10:15 PM. The QIDP indicated behavior data should be collected. The QIDP indicated she reviews data at quarterly meetings and started a new tracking sheet to document targeted behaviors. The QIDP stated, "I have been looking at that (goal and behavior data) in more detail. I am making sure we are collecting quantifiable data."</p> <p>9-3-4(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 1 of 3 sampled clients (#2) and 1 additional client (#6), the facility failed to ensure staff administered the clients' medications as ordered.</p> <p>Findings include:</p> <p>The facility's BDS (Bureau of Disabilities Services) reports and investigations were reviewed on 7/9/24 at 12:50 PM. The review indicated the following:</p> <p>1. A BDS report dated 4/8/24 for client #6 indicated, "...[PS (Program Supervisor)] noticed that the pharmacy had not sent enough Clonazepam (panic disorder), so she called (sic)</p>	W 0368	<p>Nurse will review all physicians' orders and ensure that all medications are in the home</p> <p>All staff will be trained on medication administration</p> <p>Program Supervisor will monitor at least three times per week during home visits</p> <p>Program Directors will monitor in the home at least one time per week during Site Supervisory visits</p> <p>Nurse will monitor during home visits</p>	08/11/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G763	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2024	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP COD 114 S CHESTNUT ST HUNTINGBURG, IN 47542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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>pharmacy to order more of the medication on Sunday. The pharmacy tried to fill the script but found that they needed a new prescription from the provider. [PS] and [Group Home Nurse] have both left messages with the psychiatric NP (Nurse Practitioner) [name], but they have not yet responded, and therefore [client #6] has missed her dose of Clonazepam 0.5 mg...."</p> <p>2. A BDS report dated 4/14/24 for client #6 indicated, "...On 4/14/24, Staff passing medications at 7:40 PM noticed that morning staff had passed [client 6's] night time dose of Clonazepam (0.75 mg (milligram)) instead of the morning dose (0.5 mg). Staff called the nurse [name] to get instructions on what to do. Nurse told staff to monitor for side effects and to give the morning dose (0.5 mg) in place of the night time dose (0.75 mg) since she had already had that dose today. No negative side effects were observed. Plan to resolve: Nurse and management will remind the staff responsible of the importance of triple checking the dosage and time indicated on the medication bubble pack before passing a medication. Indiana mentor will continue to monitor for individual's health and safety...."</p> <p>3. A BDS report dated 4/26/24 for client #6 indicated, "...While doing the buddy check for controlled medication counts at 12 pm, staff [DSP (Direct Support Staff) #2] noticed that there was one more Clonazepam than there should have been. She noticed that the morning staff [former DSP] had signed the back of the medication bubble pack, but did not actually pop out the pill and put it in the med cup for 7 am med pass, it was still in the bubble pack. [Client #6] missed her 7 am dose of 0.5 mg of Clonazepam. Staff called the nurse, who told them to just monitor for adverse effects and give the normal dose in the PM. Staff</p>			Persons Responsible: Area Director, Program Director, Program Supervisor, Nurse	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G763	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2024
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC		STREET ADDRESS, CITY, STATE, ZIP COD 114 S CHESTNUT ST HUNTINGBURG, IN 47542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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>did not notice any adverse effects from missing the dose of the medication. Plan to resolve: Indiana MENTOR will continue to monitor [client #6] for any adverse effects of missing the dose. MENTOR will continue to monitor for individual (sic) health and safety. Staff will be retrained on medication pass and the 3-check system for ensuring that all medications are passed appropriately...."</p> <p>4. A BDS report dated 4/29/24 for client #2 indicated, "...On 4/29/2024, Staff [DSP #2] noticed that the PM medication bubble pack was signed, and none of the morning medication pills were popped out of the bubble pack for today for [client #2]. It was discovered that staff [former DSP] had passed the evening medications instead of the morning medications for [client #2]. Most of the medications she takes (sic) the same dose in (sic) morning and evening. However, some medications she was given were not to be given until 8 pm, and some medications she did not receive that she should have at 7 am.</p> <p>The following medications were missed at 7 am: Cranberry Concentrate 500 mg capsule - used for general kidney health and UTI (Urinary Tract Infection) prevention Paroxetine HCL 40 mg - used to treat mood disorder Rosuvastatin Calcium 20 mg - used for general health maintenance and lowering cholesterol</p> <p>The following medications were received in error at 7 am, when they should have been given at 8 pm: Desmopressin Acetate 0.1 mg - used to treat frequent urination Famotidine 40 mg - used to treat acid reflux Seroquel 100 mg - used to treat bipolar disorder</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G763	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2024
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC		STREET ADDRESS, CITY, STATE, ZIP COD 114 S CHESTNUT ST HUNTINGBURG, IN 47542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 9999 Bldg. 00	<p>The following medication was given at the wrong dose: Oxcarbazepine 300 mg - used to prevent seizures - should have received 450 mg in AM and 300 mg in PM.</p> <p>Staff [DSP #2] notified the nurse, the house manager, and the program director of the error. The nurse instructed staff to watch for any adverse effects or sudden changes in mood or health. No changes or adverse effects were noticed by staff.</p> <p>Plan to Resolve: Staff [former DSP] will receive corrective action for the error. A staff re-training for medication passes has been scheduled for 5/10/24, during which time each staff will have to be signed off on a mock med pass by the program supervisor, nurse, or PD (Program Director) before passing on their own again. Indiana MENTOR will continue to monitor for (sic) the individual's health and safety...."</p> <p>The Registered Nurse (RN) was interviewed on 7/10/24 at 1:17 PM. The RN indicated staff should pass medication as ordered by the physician.</p> <p>9-3-6(a)</p> <p>State Findings 460 IAC 9-3-3 Facility Staffing (e) Prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux</p>	W 9999	<p>A new Office Coordinator has been hired and will be trained on ensuring all employee files are current Specifically for Staff #4 and Program Supervisor in the home, a TB test will be completed</p>	08/11/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/06/2024

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G763	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2024
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC		STREET ADDRESS, CITY, STATE, ZIP COD 114 S CHESTNUT ST HUNTINGBURG, IN 47542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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>(STU, PPD) tuberculosis skin test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. If the skin test result is significant (ten (10) millimeters or more), then a chest film shall be done with other physical and laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the physician.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 2 of 3 employee files reviewed (DSP- Direct Support Professional) #4 and the PS (Program Supervisor), the facility failed to ensure annual Mantoux (STU, PPD) tuberculosis (TB) screening was conducted.</p> <p>Findings include:</p> <p>On 7/8/24 at 1:26 PM, a review of the facility's employee files was conducted. DSP #4's most recent TB test was conducted on 3/14/22. There was no documentation DSP #4 had a TB test conducted since 3/14/22. The PS's (Program Supervisor) most recent TB test was conducted on 4/28/23. There was no documentation the PS had a TB test conducted since 4/28/23.</p> <p>The AD (Area Director) was interviewed on 7/10/24 at 1:02 PM. The AD indicated two of the staff members did not have a current TB test. The AD indicated they are on the list to have the TB test done with nursing in the next week or two. The AD indicated a TB test should be conducted yearly.</p> <p>9-3-3(e)</p>		<p>Program Supervisor, Program Director, and Area Director will assist the Office Coordinator in obtaining any missing documentation from the employee file</p> <p>Persons Responsible: Area Director, Program Supervisor, Office Coordinator</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G763	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2024
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC		STREET ADDRESS, CITY, STATE, ZIP COD 114 S CHESTNUT ST HUNTINGBURG, IN 47542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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