

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

PRINTED: 12/09/2024
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G763 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | (X3) DATE SURVEY COMPLETED R 12/05/2024 |
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| NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) |
| {K 000} | <p>INITIAL COMMENTS</p> <p>A 3rd Post Survey Revisit (PSR) to the 2nd PSR that exited on 10/24/24 to the 1st PSR that exited on 09/05/24 to the Life Safety Code Recertification Survey that exited on 07/25/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 12/05/24</p> <p>Facility Number: 012289 Provider Number: 15G763 AIM Number: 100249380</p> <p>At this 3rd PSR to the Life Safety Code survey, Transitional Services Sub, LLC was found in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies.</p> <p>This one story facility was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in all living areas and client sleeping rooms, plus heat detection in the attic connected to the fire alarm system. The facility has a capacity of 8 and had a census of 3 at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.6.</p> <p>Quality Review completed on 12/06/24</p> | {K 000} | |

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.