| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 15G300 | A. BUILDING 00<br>B. WING | 06/28/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| TRANSITIONAL SERVICES SUB LLC | 110 W PIKE ST<br>MARTINSVILLE, IN 46151 |

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| W 0000<br><br>Bldg. 00 | This visit was for a pre-determined full recertification and state licensure survey. This visit included the investigation of complaint #IN00428986.<br><br>Complaint #IN00428986: No deficiencies related to the allegation(s) are cited.<br><br>Dates of Survey: 6/20, 6/21 and 6/28/24.<br><br>Facility Number: 000819<br>Provider Number: 15G300<br>AIMS Number: 100249100<br><br>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.<br>Quality Review of this report completed by #15068 and #27547 on 7/23/24. | W 0000 | | |
| W 0154<br><br>Bldg. 00 | 483.420(d)(3)<br>STAFF TREATMENT OF CLIENTS<br>The facility must have evidence that all alleged violations are thoroughly investigated.<br>Based on record review and interview for 3 of 3 sampled clients (A, B and C), 2 additional clients (D and E) and 2 discharged clients (F and G), the facility failed to ensure: 1) four thorough investigations were completed and 2) three incidents of peer to peer aggression were investigated.<br><br>Findings include:<br><br>The facility's BDS (Bureau of Disability Services) incident reports were reviewed on 6/20/24 at 2:06 PM. The review indicated the following: | W 0154 | Area Director and Program Directors will be trained on completing investigations including but not limited to completing within 5 working days, through investigation, and an appropriate conclusion<br>All staff will be trained on incident reporting, ANE Policy, and documentation<br>Program Supervisor will monitor at least three times weekly during home visits<br>Program Directors will | 07/28/2024 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Bret Beauchamp | Regional Director | 08/15/2024 |

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| | 1) A BDS report dated 12/15/23 indicated, "[Client F] was agitated, being verbally aggressive towards [client G]. [Client G] charged towards [client F], punches were exchanged with little impact. No further incidents, both men have been calm and civil."<br><br>The review did not indicate documentation of a thorough investigation regarding peer to peer aggression.<br><br>2) A BDS report dated 12/23/23 indicated, "[Client G] attempted to pull a peer from day program away from another peer. [Client G] released peer and went to another room following staff verbal redirection. Staff to continue to follow each individuals' BSP (Behavior Support Plan) and monitor interactions between individuals for their health and safety."<br><br>The review did not indicate documentation of a thorough investigation regarding peer to peer aggression.<br><br>3) A BDS report dated 2/10/24 indicated, "2/9/24 a staff person reports that [staff #7] was vaping inside the home the previous evening while on shift. Staff also report the item included marijuana. Staff suspended, investigation initiated affecting [clients A, B, C, D, E and G]."<br><br>The review did not indicate documentation of a thorough investigation regarding abuse, neglect and exploitation.<br><br>4) A BDS report dated 3/28/24 indicated, "[Client B] was hit with an open hand by a peer at day program on the upper part of his back twice. Staff intervened, no injuries." | | monitor at least once weekly during Site Supervisory visits<br>Area Director will monitor at least once weekly in the home<br><br>Persons Responsible: Area Director, Program Director, Program Supervisor, Regional Director, Nurse | |

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| | The review did not indicate documentation of an investigation regarding peer to peer aggression.<br><br>5) A BDS report dated 4/2/24 indicated, "[Client A] was seen by his PCP (Primary Care Physician), staff noticed he was favoring his left hand. There was no report of any incident that might have taken place. PCP ordered x-ray, no noticeable injury. [Client A] continued to favor his left hand, PCP was contacted, a referral given to see Ortho. A soft cast was put onto the arm in hopes this would not become an issue."<br><br>The review did not indicate documentation of a thorough investigation regarding injury of unknown origin.<br><br>An interview was conducted on 6/28/24 at 2:40 PM with the AD (Area Director). The AD stated,"investigations should be thorough and include recommendations for retraining, or termination."<br><br>An interview was conducted on 6/28/24 at 3:01 PM with the PM (Program Manager). The PM indicated investigations should be thorough.<br><br>9-3-2(a) | | | |
| W 0159<br><br>Bldg. 00 | 483.430(a)<br>QIDP<br>Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who-<br>Based on observation, record review and interview for 3 of 3 sampled clients (A, B and C), the QIDP (Qualified Intellectual Disabilities Professional) failed to ensure: 1) a plan was developed for client A to wear his glasses and a | W 0159 | Program Directors will be trained on ensuring all documentation is completed in the home including goals and behavior tracking | 07/28/2024 |

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| | plan was developed to address client A's diagnosis of diastolic dysfunction (heart condition), 2) clients A, B and C staff documented the implementation of the clients' goals and training objectives, and 3) the HRC (Human Rights Committee) failed to review, approve, monitor, and/or make suggestions regarding the facility's use of door alarms, locked pens and pencils, behavior support plans and psychotropic medications for clients A, B and C.<br><br>Findings include:<br><br>1) The QIDP failed to ensure a plan was developed for client A to wear his glasses and a plan was developed to address client A's diagnosis of diastolic dysfunction. Please see W227.<br><br>2) The QIDP failed to ensure staff documented the implementation of the clients' goals and training objectives for clients A, B and C. Please see W252.<br><br>3) The QIDP failed to ensure the HRC (Human Rights Committee) reviewed, approved, monitored, and/or make suggestions regarding the facility's use of door alarms, locked pens and pencils, behavior support plans and psychotropic medications for clients A, B and C. Please see W262.<br><br>9-3-3(a) | | Program Directors will be trained on QIDP responsibilities including, appropriate goals, updating all individual plans, and ensuring HRC approval for all restrictions<br>Specifically for Client A, a goal for glasses will be put into place and diastolic dysfunction will be added to risk plan<br>All staff will be trained on individuals' plans including all ISPs and BSPs<br>All staff will be trained on documentation<br>Program Supervisor will monitor at least three times weekly during home visits<br>Program Director will monitor at least once weekly during Site Supervisor Visits<br><br>Persons Responsible: Area Director, Program Director, Program Supervisor, Nurse | |
| W 0227<br><br>Bldg. 00 | 483.440(c)(4)<br>INDIVIDUAL PROGRAM PLAN<br>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by | | | |

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| | paragraph (c)(3) of this section.<br>Based on observation, record review and interview for 1 of 3 sampled clients (A), the facility failed to ensure: 1) a plan was developed for client A to wear his glasses, and 2) a plan was developed to address client A's diagnosis of diastolic dysfunction (heart condition).<br><br>Findings include:<br><br>1) An observation was conducted on 6/20/24 from 4:14 PM until 6:00 PM and on 6/21/24 from 7:00 AM until 9:15 AM at the group home. At 4:14 PM client A was sitting on the couch in the living room. Client A was not wearing glasses. At 4:20 PM client A was sitting at the table completing a puzzle with staff's assistance. Client A was not wearing glasses. At 5:09 PM client A came out of his bedroom. Client A was not wearing glasses. At 5:31 PM client A sat down for dinner. Client A was not wearing glasses.<br>On 6/21/24 at 7:00 AM client A walked out of his bedroom. Client A was not wearing glasses. At 7:15 AM client A finished his breakfast. Client A was not wearing glasses. At 7:22 AM client A exited his bedroom and sat on the couch in the living room. Client A was not wearing glasses.<br><br>Client A's record was reviewed on 6/21/24 at 11:28 AM. Client A's vision consult dated 1/8/24 indicated, "has a glasses RX (prescription)." Client A's ISP (Individualized Support Plan) dated 5/1/2024 indicated client A did not have a plan to wear his glasses.<br><br>An interview was conducted on 6/28/24 at 3:01 PM with the PM (Program Manager). The PM stated, "historically [client A] won't wear his glasses. We should have a plan for him to wear them." | W 0227 | Specifically for Client A, a goal for glasses will be put into place and diastolic dysfunction will be added to risk plan<br>Program Director will be trained on setting appropriate goals<br>All staff will be trained on individuals' plans including all ISPs and BSPs<br>All staff will be trained on documentation<br>Nurse will monitor during home visits<br>Program Supervisor will monitor at least three times weekly during home visits<br>Program Director will monitor at least weekly during supervisor visits<br><br>Persons Responsible: Area Director, Program Director, Program Supervisor, Nurse | 07/28/2024 |

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| | An interview was conducted on 6/28/24 at 3:24 PM with the LPN (Licensed Practical Nurse). The LPN stated, "if I remember correctly the staff reported [client A] would not wear them so the Doctor didn't give a script for glasses. We could try to implement a training goal."<br><br>2) Client A's record was reviewed on 6/21/24 at 11:28 AM. A telephone consult with [doctor's office] dated 3/13/24 with indicated, "Please let patient's caregivers know that [client A's] echocardiogram shows moderate diastolic dysfunction - this is when the main chamber of the heart (left ventricle) does not relax properly. It usually is a sign or precursor of heart failure. I am going to place a referral to Cardiology to see if they want to do any further testing. I am also going to send in a prescription for a diuretic (water pill) that they should give him PRN (as needed) if they notice any swelling."<br><br>Client A's PO (Physician's Orders) dated 6/1/24 indicated, "an order for Furosemide (treatment for a build up of fluid in the body) 20 mg (milligram) tablet take 1 tablet by mouth daily as needed if edema noted. DX (Diagnosis) swelling."<br><br>Client A's HRP (High Risk Protocols) dated 3/1/23 did not include a plan for moderate diastolic dysfunction.<br><br>An interview was conducted on 6/28/24 at 2:40 PM with the AD (Area Director). The AD stated, "if it is a medical concern, there should have been a protocol developed and the staff trained on it."<br><br>An interview was conducted on 6/28/24 at 3:24 PM with the LPN. The LPN stated, "I was working on trying to get clarification on the order | | | |

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| | since it was the NP (Nurse Practitioner) who ordered the Lasix and not the Cardiologist. A protocol should have been implemented for better training for the staff."<br><br>9-3-4(a) | | | |
| W 0252<br><br>Bldg. 00 | 483.440(e)(1)<br>PROGRAM DOCUMENTATION<br>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.<br>Based on record review and interview for 3 of 3 sampled clients (A, B and C), the facility failed to ensure staff documented the implementation of the clients' goals and training objectives.<br><br>Findings include:<br><br>1) A record review was completed on 6/21/24 at 11:28 AM of client A's ISP (Individualized Support Plan) dated 5/1/24. Client A's objectives indicated the following objectives were to be implemented:<br><br>1A) "Daily, [client A] will put his clothes in the washer with no more than 1 verbal prompt 50% of the time for 3 consecutive months." A review of the goal history dated 6/21/24 indicated the goal was implemented the following amount of times per month:<br><br>-January 2024: 2 times<br>-February 2024: 0 times<br>-March 2024: 0 times<br>-April 2024: 0 times<br>-May 2024: 0 times<br><br>Data indicated this goal was not implemented daily as written. | W 0252 | Area Director and Program Directors will be trained on ensuring all documentation is completed in the homes<br>All staff will be trained on documentation including objectives, behavior plans, and daily notes<br>Program Director will monitor at least once weekly during weekly Site Supervisory visits<br>Program Supervisor will monitor at least three times weekly during home visits<br><br>Persons Responsible: Area Director, Program Director, Program Supervisor | 07/28/2024 |

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| | 1B) "Daily, will come to dining room for his med pass in the morning with no more than 1 verbal prompt 50% of the time for 3 consecutive months." A review of the goal history dated 6/21/24 indicated the goal was implemented the following amount of times per month:<br><br>-January 2024: 17 times<br>-February 2024: 17 times<br>-March 2024: 16 times<br>-April 2024: 16 times<br>-May 2024: 0 times<br><br>Data indicated this goal was not implemented daily as written.<br><br>1C) "Bimonthly, will hand his bank card to the cashier to make a purchase with no more than 2 verbal prompts 100% of the time for 3 consecutive months." A review of the goal history dated 6/21/24 indicated the goal was implemented the following amount of times per month:<br><br>-January 2024: 1 time<br>-February 2024: 0 times<br>-March 2024: 0 times<br>-April 2024: 0 times<br>-May 2024: 0 times<br><br>Data indicated this goal was not implemented bimonthly as written.<br><br>1D) "Daily, will take a drink and/or wipe his mouth with a napkin in between bites of food with no more than 3 verbal prompts 50% of the time for 3 consecutive months." A review of the goal history dated 6/21/24 indicated the goal was implemented the following amount of times per month: | | | |

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| | -January 2024: 3 times<br>-February 2024: 0 times<br>-March 2024: 0 times<br>-April 2024: 0 times<br>-May 2024: 0 times<br><br>Data indicated this goal was not implemented daily as written.<br><br>1E) "Two times a week, will take his lunch from his lunch bag and place onto his plate." A review of the goal history dated 6/21/24 indicated the goal was implemented the following amount of times per month:<br><br>-January 2024: 8 times<br>-February 2024: 5 times<br>-March 2024: 7 times<br>-April 2024: 0 times<br>-May 2024: 0 times<br><br>Data indicated this goal was not implemented biweekly as written.<br><br>2) A record review was completed on 6/21/24 at 3:00 PM of client B's ISP dated 5/1/24. Client B's objectives indicated the following objectives were to be implemented:<br><br>2A) "Daily, in the morning, will brush his teeth thoroughly with no more than 3 verbal prompts 50% of the time for 3 consecutive months." A review of the goal history dated 6/21/24 indicated the goal was implemented the following amount of times per month:<br><br>-January 2024: 1 time<br>-February 2024: 0 times<br>-March 2024: 0 times | | | |

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| | -April 2024: 0 times<br>-May 2024: 0 times<br><br>Data indicated this goal was not implemented daily as written.<br><br>3) A record review was completed on 6/21/24 at 1:50 PM of client C's ISP dated 5/1/23. Client C's objectives indicated the following objectives were to be implemented:<br><br>3A) "Daily, during a med pass, will state the name of all his medications and the reasons prescribed with no more than 2 verbal prompts 25% of the time for 3 consecutive months." A review of the goal history dated 6/21/24 indicated the goal was implemented the following amount of times per month:<br><br>-January 2024: 0 times<br>-February 2024: 0 times<br>-March 2024: 0 times<br>-April 2024: 0 times<br>-May 2024: 0 times<br><br>Data indicated this goal was not implemented daily as written.<br><br>3B) "Daily, at meals, will take a break between bites of food (wipe his mouth with a napkin, take a drink, put down his fork) w/no more than 1 verbal prompts 25% of the time for 3 consecutive months. A review of the goal history dated 6/21/24 indicated the goal was implemented the following amount of times per month:<br><br>-January 2024: 13 times<br>-February 2024: 16 times<br>-March 2024: 16 times<br>-April 2024: 16 times | | | |

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| | -May 2024: 0 times<br><br>Data indicated this goal was not implemented daily as written.<br><br>An interview was conducted on 6/28/24 at 3:01 PM with the PM (Program Manager). The PM stated, "goals are to be implemented per the guidelines of the objective and documented when run."<br><br>An interview was conducted on 6/28/24 at 3:10 PM with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP stated, "goals are to be implemented as soon as possible." The QIDP indicated a medication goal could be implemented two times a day, once formally and informally. The QIDP stated, "staff should document every shift in the daily notes when the training goals are run daily."<br><br>9-3-4(a) | | | |
| W 0262<br><br>Bldg. 00 | 483.440(f)(3)(i)<br>PROGRAM MONITORING & CHANGE<br>The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.<br>Based on observation, record review and interview for 3 of 3 sampled clients (A, B and C), the facility's HRC (Human Rights Committee) failed to review, approve, monitor, and/or make suggestions regarding the facility's use of door alarms, locked pens and pencils, behavior support plans and psychotropic medications.<br><br>Findings include: | W 0262 | All restrictions will updated in individuals' plans and HRC will be contacted for all restrictions<br>Program Director will be trained on ensuring Human Rights Committee approval is obtained for all restrictions<br>All staff will be trained on any updates to plans and client | 07/28/2024 |

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| | 1) An observation was conducted at the group home on 6/20/24 from 4:14 PM until 6:00 PM. When the door of the home opened an alarm sounded. At 4:50 PM client A got up from the couch and went out the door to the porch. When the door was opened an alarm sounded. At 5:03 PM the door to the home was opened and an alarm sounded. At 5:11 PM clients B, C and E opened the door to the porch an alarm sounded. At 6:00 PM when the surveyor opened the door of the home an alarm sounded. This affected clients A, B and C.<br><br>2) An observation was conducted at the group home on 6/21/24 from 7:00 AM until 9:00 AM. At 7:00 AM when the door opened for the surveyor, an alarm sounded. At 7:26 AM client C selected a pen from a container on the counter and marked the day on the calendar hanging in the office. At 7:29 AM DSP (Direct Support Professional) #1 stated, "pens/pencils are stored in the office due to [client A] will obsess over them." This affected clients A, B and C.<br><br>Client A's record review was completed on 6/21/24 at 11:28 AM. Client A's BSP (Behavior Support Plan) dated 5/29/24 did not contain HRC approval for door alarms, locked pens/pencils, behavior support plans and the use of psychotropic medication. Client A's record contained HRC approval for the lock on the kitchen door.<br><br>Client B's record review was completed on 6/21/24 at 3:00 PM. Client B's BSP dated 6/10/24 did not contain HRC approval for the use of door alarms, locked pens/pencils, behavior support plans and the use of psychotropic medication. Client B's record contained HRC approval for the lock on the kitchen door. | | rights<br>Program Supervisor will monitor at least three times weekly during home visits<br>Program Director will monitor at least once weekly during weekly Site Supervisory visits<br><br>Persons Responsible: Area Director, Program Director, Program Supervisor | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 15G300 | A. BUILDING 00<br>B. WING | 06/28/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| TRANSITIONAL SERVICES SUB LLC | 110 W PIKE ST<br>MARTINSVILLE, IN 46151 |

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|---|---|---|---|---|
| | Client C's record review was completed on 6/21/24 at 1:50 PM. Client C's BSP dated 6/7/24 did not contain HRC approval for the use of door alarms, locked pens/pencils, behavior support plans and the use of psychotropic medication. Client C's record contained HRC approval for the lock on the kitchen door.<br><br>An interview was conducted on 6/28/24 at 2:40 PM with the AD (Area Director). The AD stated, "the HRC should have approved all the plans and the restrictions included in the plans." The AD stated, "approval should have been given for all restrictions, not just the kitchen door."<br><br>An interview was conducted on 6/28/24 at 3:10 PM with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP stated, "yes, if the BSP contains restrictions then it should be approved by the HRC." The QIDP indicated, the BSP itself and psychotropic medication should be reviewed by the HRC.<br><br>9-3-4(a) | | | |
| W 0460<br><br>Bldg. 00 | 483.480(a)(1)<br>FOOD AND NUTRITION SERVICES<br>Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.<br>Based on observation, record review and interview for 3 of 5 clients living in the group home (A, C, and E), the facility failed to ensure a drink was provided during the breakfast meal.<br><br>Findings include:<br><br>An observation was conducted on 6/21/24 from 7:00 AM until 9:00 AM. At 7:14 AM client A sat | W 0460 | All staff will be trained on all diet plans and meal preparation<br>Program Supervisor will monitor at least three times weekly during home visits<br>Program Director will monitor at least once weekly during site supervisor visits<br>Nurse will monitor during | 07/28/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 15G300 | A. BUILDING 00<br>B. WING | 06/28/2024 |

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| | down at the table. He was offered his choice of cereal. There were 2 containers of cereal on the table and one gallon of milk. Client A scooped cereal out of the container and into his bowl. There was not a cup at client A's place setting. Client A was assisted with pouring milk on his cereal. At 7:20 AM clients C and E were sitting at the table eating breakfast. Clients C and E did not have cups available at the table. Clients A, C and E were not offered a drink with their breakfast meal.<br><br>On 6/21/24 at 7:40 AM a review of the posted menu dated Summer 2024 indicated, "1/2 c (cup) Orange Juice, 1 c skim milk/coffee/tea."<br><br>An interview was conducted on 6/21/24 at 9:15 AM with the AS (Area Supervisor). The AS stated, "the menu should be followed. They should be offered drinks."<br><br>An interview was conducted on 6/28/24 at 3:24 PM with the LPN (Licensed Practical Nurse). The LPN stated, "drinks should absolutely be offered, it goes with meals."<br><br>9-3-8(a) | | visits to the home<br><br>Persons Responsible: Program Supervisor, Area Director, Nurse | |