STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G763	A. BUILDING 00 B. WING	08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSITIONAL SERVICES SUB LLC	114 S CHESTNUT ST HUNTINGBURG, IN 47542

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W 0000 Bldg. 00	This visit was for a Post Certification Revisit (PCR) to the pre-determined full recertification and state licensure survey and the investigation of complaints #IN00391919 and #IN00392577 completed on 5/1/23. Complaint #IN00391919: Corrected. Complaint #IN00392577: Corrected. Dates of Survey: 8/8, 8/9 and 8/10/23. Facility Number: 012289 Provider Number: 15G763 AIMS Number: 10049380 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 8/29/23.	W 0000		
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review and interview for 6 of 6 clients living in the group home (A, B, C, D, E and F), the facility's governing body failed to exercise operating direction over the facility by failing to implement the 5/1/23 POC (Plan of Correction) regarding maintaining the home in good repair. Findings include: An observation was conducted at the group home	W 0104	W104 Governing Body The governing body must exercise general policy, budget, and operating directions over the facility - Management will ensure that all repairs in the home are completed in a timely manner - A contractor has been contacted to address all repairs	09/10/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Bret Beauchamp | Regional Director | 09/08/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds 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 disclo 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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	on 8/8/23 from 5:06 PM until 6:49 PM. During the observation the following repairs had not been completed affecting clients A, B, C, D, E and F: -A rip in the linoleum flooring in the dining room. -The linen closet on the women's side of the home had a hole in the door. -The chair rail behind two living room chairs was scraped and missing paint. -A rip in the linoleum floor in the living room. -A spindle from the railing on the front porch was pulled away from the wood exposing nails. On 8/9/23 at 10:15 AM, a review of the facility's 5/1/23 POC (Plan of Correction) was conducted. The POC indicated, in part, "Management will ensure that all repairs in the home are completed in a timely manner. A contractor has been contacted to address all repairs needed in the home. PD (Program Director) and PS (Program Supervisor) will be trained on ensuring repairs are addressed in a timely manner. All staff will be trained on reporting any repairs needed for the home to management in a timely manner. PS will monitor the home at least three times weekly during home visits. PD will monitor at least once weekly during Site Supervisory visits." An interview was conducted on 8/9/23 at 1:30 PM with the AD (Area Director). The AD indicated the contractor will not be starting on the home's repairs until next week. The AD stated, "The PD was terminated and did not complete the retraining with the PS regarding completing repairs were addressed in a timely manner." An interview was conducted on 8/10/23 at 10:01 AM with the RD (Regional Director). The RD stated,"the contractor will be starting on the home's repairs in the next week."		needed in the home - Program Director and Program Supervisor will be trained on ensuring repairs are addressed in a timely manner - All staff will be trained on reporting any repairs needed for the home to management in a timely manner - Area Director will be trained on ensuring the POC is completed in a timely manner - Program Supervisor will monitor the home at least three times weekly during home visits - Program Director will monitor at least once weekly during Site Supervisory visits Persons Responsible: Area Director, Program Director, Program Supervisor	

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	This deficiency was cited on 5/1/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-1(a)			
W 0140 Bldg. 00	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview for 2 of 3 sampled clients (B and C) and 2 additional clients (D and E), the facility failed to ensure a complete accounting of clients (B, C, D and E's) finances to the penny. Findings include: On 8/8/23 at 6:10 PM a review of client B, C, D and E's debit card ledger indicated: 1) Client B's ledger indicated a debit card balance on 7/1/23 was $52.00. The automated card balance system indicated client B had a balance of $88.57. 2) Client C's ledger indicated a debit card balance on 7/1/23 was $38.51. The automated card balance system indicated client C had a balance of $112.44. 3) Client D's ledger indicated a debit card balance on 7/1/23 was $171.17. The automated card balance system indicated client D had a balance of $218.56. 4) Client E's ledger indicated a debit card balance on 7/1/23 was $ 57.16. The automated card balance system indicated client E had a balance of	W 0140	W140 Client Finances The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients - Management will ensure audits are completed for all clients in the home - Once audits are completed, clients will be reimburse for any fund unaccounted for - Management will ensure that debit cards are available for all clients to access their funds - Program Supervisor will be trained to ensure that finance ledgers are current and accurate - A new Program Director has been hired and will be trained on completing monthly audits - Program Supervisor will monitor finances at least three times weekly during home visits - Program Director will	09/10/2023

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	$142.69. An interview was conducted on 8/8/23 at 6:30 PM with the PS (Program Supervisor). The PS stated, "I have not had much training regarding finances." The PS stated, "the PD (Program Director) was supposed to train me and she is no longer with the company." An interview was conducted on 8/9/23 at 1:30 PM with the AD (Area Director). The AD stated, "Finances should balance to the penny." The AD indicated the former PD was supposed to train the PS and it did not happen. This deficiency was cited on 5/1/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-2(a)		monitor finances during weekly Site Supervisory visits Persons Responsible: Area Director, Program Director, Program Supervisor	
W 0159 Bldg. 00	483.430(a) QIDP Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who- Based on record review and interview for 3 of 3 sampled clients (A, B and C), the QIDP (Qualified Intellectual Disabilities Professional) failed to ensure 1) clients A, B and C's formal training objectives were being documented as written, and 2) the CFAs (Comprehensive Functional Assessments) were reviewed annually and updated as needed for clients A, B and C. Findings include: 1) The QIDP failed to ensure clients A,B and C's formal training objectives were being documented	W 0159	W159 QIDP - Quarterly reviews will be completed for all clients in the home - Comprehensive Functional Assessments will be completed and reviewed for all clients in the home - Program Director and Area Director will be trained on QIDP duties including but not limited to assessments, quarterly reviews,	09/10/2023

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	as written. Please see W252. 2) The QIDP failed to ensure the CFAs were reviewed annually and updated as needed for clients A, B and C. Please see W259. This deficiency was cited on 5/1/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-3(a)		monthly summaries, and annual ISPs - Specifically for Client A, the IDT will meet to discuss BSP and include suicidal ideation - All staff will be trained on all Individual Support Plans and Behavior Support Plans - All staff will be trained on documentation in the home - Program Supervisor will monitor and address any issues at least three times weekly during home visits - Program Director will monitor and address any issues in the home at least once weekly during Site Supervisory visits Persons Responsible: Area Director, Program Director, Program Supervisor, Nurse	
W 0252 Bldg. 00	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. 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. Findings include: 1) A record review was completed on 8/9/23 at 11:00 AM of client A's ISP (Individualized Support Plan) dated 7/31/23. Client A's objectives	W 0252	W252 Program Documentation Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms - Program Director and Program Supervisor will be trained on ensuring that objectives and all	09/10/2023

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	indicated the following objectives were to be implemented. "Will identify her medication and what they are for once a day." -May 2023: 0 times -June 2023: 12 times. -July 2023: 21 times. Data indicated this goal was not implemented daily as written. "Will shower or take a bath once a day." -May 2023: 0 times -June 2023: 5 times. -July 2023: 14 times. Data indicated this goal was not implemented daily as written. 2) A record review was completed on 8/9/23 at 10:00 AM of client B's ISP dated 7/26/23. Client B's objectives indicated the following objectives were to be implemented. "Will work on taking belongings from her peers daily [sic]." -May 2023: 0 times -June 2023: 12 times. -July 2023: 22 times. Data indicated this goal was not implemented daily as written. "Will respect the personal boundaries of her peers daily."		documentation are being completed in the home - All staff will be trained on all Clients' ISPs in the home - All staff will be trained on documentation including but not limited to objectives - Program Supervisor will monitor at least three times weekly during home visits - Program Director will monitor at least weekly during weekly Site Supervisory visits Persons Responsible: Area Director, Program Director, Program Supervisor	

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	-May 2023: 0 times -June 2023: 12 times. -July 2023: 24 times. Data indicated this goal was not implemented daily as written. "Will state a positive effect of her oxcarbazepine (seizures) daily." -May 2023: 0 times -June 2023: 12 times. -July 2023: 19 times. Data indicated this goal was not implemented daily as written. 3) A record review was completed on 8/9/23 at 1:00 PM of client C's ISP dated 7/27/23. Client C's objectives indicated the following objectives were to be implemented. "Will daily during PM medication pass sanitize his hands." -May 2023: 0 times -June 2023: 12 times. -July 2023: 24 times. Data indicated this goal was not implemented daily as written. "Will daily after dinner take his plate to the kitchen." -May 2023: 0 times -June 2023: 12 times. -July 2023: 24 times. Data indicated this goal was not implemented			

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	daily as written. An interview was conducted on 8/9/23 at 1:30 PM with the AD (Area Director). The AD stated, "staff should implement objectives as written." An interview was conducted on 8/10/23 at 3:22 PM with the RD (Regional Director). The RD stated, "if goals are to be implemented daily, then staff should implement it." 9-3-4(a)			
W 0259 Bldg. 00	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview for 3 of 3 sampled clients (A, B and C), the facility failed to ensure the CFAs (Comprehensive Functional Assessments) were reviewed annually and updated as needed per client A, B and C's needs. Findings include: 1) Client A's record was reviewed on 8/9/23 at 11:00 AM. Client A's record indicated her CFA was not completed. Client A's record did not indicate documentation of an annual review of the CFA. 2) Client B's record was reviewed on 8/9/23 at 10:00 AM. Client B's record indicated her CFA was completed on 5/10/21. Client B's record did not indicate documentation of an annual review of the CFA since 5/10/21. 3) Client C's record was reviewed on 8/9/23 at 1:00	W 0259	W259 Program Monitoring and Change - Program Director and Area Director will be trained on Individual Support Plans and Comprehensive Functional Assessments - For Clients B and C, Comprehensive Functional Assessments will be completed for each Client - Upon completion of Comprehensive Functional Assessments, a new Individual Support Plan will be completed for Clients B and C - Interdisciplinary Team will meet to discuss assessments and updated Individual Support Plans for Clients B and C	09/10/2023

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	PM. Client C's record indicated his CFA was completed on 4/21/21. Client C's record did not indicate documentation of an annual review of the CFA since 4/21/21. An interview was conducted on 8/9/23 at 1:30 PM with the AD (Area Director). The AD stated, "CFA's should be completed or reviewed annually." An interview was conducted on 8/10/23 at 3:22 PM with the RD (Regional Director). The RD stated, "the PD (Program Director) is responsible for completing or reviewing the CFA annually." This deficiency was cited on 5/1/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-4(a)		- All staff will be trained on any updates Individual Support Plans - Program Supervisor will monitor at least three times weekly during home visits - Program Director will monitor and address any issues in the home during weekly Site Supervisory visits Persons Responsible: Area Director, Program Director, Program Supervisor	
W 0436 Bldg. 00	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review and interview for 1 of 3 sampled clients (B), the facility failed to ensure client B wore her hearing aid. Findings include: An observation was conducted at the group home on 8/8/23 from 5:06 PM until 6:49 PM. At 5:14 PM client B was prompted to go wash her hands	W 0436	W436 Space and Equipment - Specifically for Client B, the IDT will meet to discuss wearing hearing aid and a goal will be put into place for daily use - Program Director will update Individual Support Plan to include Client B to wear hearing aid daily - Staff will be trained on	09/10/2023

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	before dinner. Client B got up and was observed to not be wearing a hearing aid. During dinner client B was talking loudly about events she had participated at Special Olympics. At 5:35 PM client B finished her dinner, got up from the table and put her plate in the kitchen. Client B did not have a hearing aid on. An observation was conducted at the agency day program on 8/9/23 from 11:36 AM until 12:30 PM. Client B was sitting at a table in the day program area and was finishing lunch. Client B got up from her chair at 11:40 AM and threw her trash away. Client B was observed to not be wearing a hearing aid. At 12:00 PM client B informed the surveyor she did not like to sing karaoke with the group. Client B did not have her hearing aid on. Client B's record review was reviewed on 8/9/23 at 10:00 AM. Client B's PO (physician orders) dated 7/1/23 indicated, "[client B] wears hearing aid daily." Client B's hearing consult dated 11/7/19 indicated, "continue to wear left hearing aid." Client B's ISP (Individualized Support Plan) dated 7/26/23 did not indicate a plan for refusal to wear her hearing aid. An interview was conducted with client B on 8/9/23 at 11:39 AM. Client B stated, "I sometimes will wear my hearing aid. I keep it in the office." Client B indicated staff do not prompt her to wear her hearing aid. An interview was conducted on 8/9/23 at 11:10 AM with the RN (Registered Nurse). The RN stated, "[Client B] refuses to wear her hearing aid. She has an upcoming appointment to have the wax removed from her ears, then she will have a new hearing test completed to see if she really needs them."		updates to Individual Support Plan - Program Supervisor will monitor at least three times weekly during home visits - Program Director will monitor at least once weekly during Site Supervisor Visit Persons Responsible: Program Director, Program Supervisor, Area Director	

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	This deficiency was cited on 5/1/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-7(a)			