

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

PRINTED: 05/24/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G300		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/23/2021	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151			
(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 0000 Bldg. 00	<p>This visit was for the Post Certification Revisit (PCR) to the investigation of complaint #IN00347983 and the Covid-19 focused infection control survey completed on 3/9/21.</p> <p>Complaint #IN00347983: Corrected.</p> <p>Unrelated deficiency cited.</p> <p>Survey dates: April 22 and 23, 2021</p> <p>Facility Number: 000819 Provider Number: 15G300 AIM Number: 100249100</p> <p>This deficiency also reflects state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 5/3/21.</p>		W 0000				
W 0368 Bldg. 00	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>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 clients in the sample (B) and two additional clients (D and G), the facility failed to ensure staff administered the clients' medications as ordered.</p> <p>Findings include:</p> <p>On 4/22/21 at 12:36 PM, a review of the facility's incident reports was conducted and indicated the following medication errors with no adverse reactions:</p>		W 0368	<p>All staff in the home will be retrained to follow Medication Administration procedures and ensuring all medications are administered per Physicians Orders.</p> <p>Supervisory observations will be completed weekly for one month, two times per month for one month and then at least monthly ongoing to monitor medications are administered as ordered.</p>		05/23/2021	

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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	<p>1) On 3/7/21 at 8:00 AM, client G did not receive Olanzapine (antipsychotic).</p> <p>2) On 3/7/21 at 12:00 PM, client B did not receive Lactulose (constipation).</p> <p>3) On 3/17/21 at 8:00 PM, client D did not receive Naltrexone, Guanfacine (attention deficit hyperactivity disorder), Vraylar (oppositional defiant disorder) and Cetirizine (antihistamine).</p> <p>4) On 3/28/21 at 8:00 PM, client D did not receive Naltrexone, Guanfacine, Vraylar and Cetirizine.</p> <p>On 4/22/21 at 12:50 PM, the Area Director indicated the clients' medications should be administered as ordered.</p> <p>9-3-6(a)</p>		Persons Responsible: Program Supervisor, Program Director, Nurse				