STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G300	A. BUILDING 00 B. WING	04/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL SERVICES SUB LLC	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	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. Complaint #IN00347983: Corrected. Unrelated deficiency cited. Survey dates: April 22 and 23, 2021 Facility Number: 000819 Provider Number: 15G300 AIM Number: 100249100 This deficiency also reflects state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 5/3/21.	W 0000		
W 0368 Bldg. 00	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 clients in the sample (B) and two additional clients (D and G), the facility failed to ensure staff administered the clients' medications as ordered. Findings include: 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:	W 0368	All staff in the home will be retraine to follow Medication Administration procedures and ensuring all medications are administered per Physicians Orders. 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.	05/23/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G300	A. BUILDING 00 B. WING	04/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	1) On 3/7/21 at 8:00 AM, client G did not receive Olanzapine (antipsychotic). 2) On 3/7/21 at 12:00 PM, client B did not receive Lactulose (constipation). 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). 4) On 3/28/21 at 8:00 PM, client D did not receive Naltrexone, Guanfacine, Vraylar and Cetirizine. On 4/22/21 at 12:50 PM, the Area Director indicated the clients' medications should be administered as ordered. 9-3-6(a)		Persons Responsible: Program Supervisor, Program Director, Nurse	