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	02/21/2024

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TRANSITIONAL SERVICES SUB LLC	114 S CHESTNUT ST HUNTINGBURG, IN 47542

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W 0000 Bldg. 00	This visit was for the investigation of complaint #IN00426817. Complaint #IN00426817: Federal and state deficiencies related to the allegation(s) are cited at W149, W154, W156, W157, W159, W164, W189 and W240. Dates of Survey: 2/19/24, 2/20/24 and 2/21/24. Facility Number: 012289 Provider Number: 15G763 AIMS Number: 100249380 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 3/4/24.	W 0000		
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 1 of 3 sampled clients (A), the facility failed to implement its written policy and procedures to ensure incidents of SIB (Self-Injurious Behavior) resulting in emergency medical evaluation were thoroughly investigated within 5 business days and to develop and implement effective corrective measures to prevent recurrence. Findings include: The facility's Bureau of Disabilities Services (BDS) reports, internal incident reports and	W 0149	Area Director and Program Directors will be trained on completing investigations Area Director and Program Directors will be trained on completing any recommendations due to investigations Area Director and Program Directors will be trained on reporting all incidents to BDS within 24 hours of the incident Program Director will complete IDTs with all individuals	03/22/2024

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

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	investigations were reviewed on 2/19/24 at 11:40 AM and indicated the following: A) A BDS report dated 11/27/23 indicated the following: "Individual got a call from her sister and her sister told her that she had recently cut her arms. This individual called their mother and her mother asked her if she was going to cut herself too. Individual then took the back of a video game, went to the bathroom, closed and blocked the door with her body, and then scraped her right arm with the back she had taken off. Police were notified and arrived. Individual was taken to the hospital. Plan to resolve: Staff will continue to follow the behavior plan and be supportive as needed." An investigation was not available for review for the BDS report dated 11/27/23. The AD (Area Director) was interviewed on 2/20/24 at 1:36 PM. The AD indicated the QI (Quality Improvement) department did not notify him to complete an investigation for the incident on 11/27/23. B) A BDS report dated 1/20/24 indicated the following: "[Client A] stated to staff that she swallowed a thumb tack around 9:10 pm EST. 911 was called. The police showed up before the ambulance and the ambulance got there 9:35 pm. She was transported to [name] Hospital where she was admitted, She is currently in hospital. Plan to resolve: Keep in contact with hospital, follow all discharge orders. All thumb tacks have been removed from the home." An investigation dated 1/24/24 indicated the		in the home to ensure BSPs are appropriate Program Director will meet with State Clinical Director Bi-Weekly to discuss BSPs All staff will be trained on all individuals' BSPs in the home All staff will be trained on incident reporting Program Supervisor will monitor 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, Regional Director	

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	following: "Incident Summary... Witnesses Interviewed including Job titles or relationship to the Network: [DSP (Direct Support Professional) #5], [DSP #1] and [DSP #6] Documents or Files reviewed: PCISP (Person Centered Individualized Support Plan), Hospital Discharge Paperwork... [Client A] stated to staff that she swallowed a thumb tack around 9:10 pm EST. 911 was called. The police showed up before the ambulance and the ambulance got there 9:35 pm. She was transported to [name] Hospital where she was admitted. She is currently in the hospital... Factual Findings [Client A] was on the phone with her sister and her sister told her that she swallowed a thumb tack and that she (client A) should do the same thing. [Client A] then found a thumb tack in the home. Staff witnessed [Client A] put something in her mouth and swallowed it. The staff stated that they were unsure if she put a tack in her mouth and swallowed it. However, because she stated that she did they immediately called 911 and had the individual transported to the hospital. All safety protocols were followed. There were no policy or procedure violations. Conclusions of Fact (i.e. Investigator's conclusions to the questions and issues initially raised by the incident) Individual was taken to the hospital and the hospital took an xray. Hospital stated item was not retrievable. Hospital discharged the individual with Miralax (constipation) and asked for the house to follow up with PCP (Primary Care Physician)." The investigation was not thorough as evidenced			

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	by: -The investigation did not include the number of staff present. -There was no interview with staff #2, #3, #4 or the PS (Program Supervisor) included in the investigation. -There were no interviews with clients A, B, C, D, E, F or G in the investigation (or indicate if clients were present). -There was no review of client A's BSP (Behavior Support Plan) in the investigation. -The investigation did not indicate whether or not staff #1, #5 or #6 implemented client A's BSP as written. -The investigation did not include recommendations for measures to prevent recurrence. C) A BDS report dated 1/23/24 indicated the following: "On 1/23/24 @ 9:50 pm EST [client A's] roommate came to the office and told us [client A] took one of her earrings and swallowed it. [Client A] was asked if she did in fact swallow an earring and she said yes. We then called 911, Police and Fire & Rescue showed up at 9:55 pm. After initially denying she swallowed the earring she finally admitted to it. She stated she hopes she dies. The ambulance arrived at 10:10 pm, they left with her at 10:20 pm and took her to [name] Hospital. They called at 12:05 am stating she was being discharged. Staff picedk (sic) her up. She arrived back at the group home at 1:30 am. At 1:50 am on 1/24/24, [Client A] came back from the hospital, 20 minutes later she was opening and closing her dresser drawers. Apparently she has (sic) thumb tacks hidden in one of them. She was being belligerent and refused to follow direction. She said she swallowed a thumb tack and 2 minutes later said she was going to swallow another one. I			

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	observed her putting something in her mouth and she swallowed it with water. 911 was called, she then went in and threatened her roommate with putting something in her water. The police showed up at 2:00 am and she argued with them. The ambulance showed up around 2:10 am. After arguing with police and EMS (Emergency Medical Services) they took her back to the hospital at approximately 2:25 am with the earring from the first Incident and 2 thumb tacks in her stomach. She was admitted to [name] Hospital. She is currently still there." An investigation dated 1/25/24-2/2/24 indicated the following: "...Witnesses Interviewed including Job titles or relationship to the Network: [DSP #3], [DSP #1] and [DSP #6] Documents or Files reviewed: PS (Program Supervisor) filed the Incident Report on the state portal as well. Program Director submitted the report on IMS (Incident Management System)... Factual Findings: [client A's] roommate came to the office and told us [client A] took one of her earrings and swallowed it. [Client A] was asked if she did in fact swallow an earring and she said yes. Next staff called 911, Police and Fire & Rescue showed up at 9:55 pm. After initially denying she swallowed the earring she finally admitted to it. She stated she hopes she dies. The ambulance arrived at 10:10 pm. They left with her at 10:20 pm and took her to [name] Hospital. They called at 12:05 am stating she was being discharged. Staff picked her up. 20 minutes later she was opening and closing her dresser drawers. She had thumb tacks hidden in one of them. She was being belligerent and refused to follow direction. She said she swallowed a thumb tack and 2 minutes later said she was going to swallow another one. Staff observed her putting			

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	something in her mouth and she swallowed it with water. 911 was called, she then went in and threatened her roommate with putting something in her water. The police showed up at 2:00 am and she argued with them. The ambulance showed up around 2:10 am. After arguing with police and EMS they took her back to the hospital at approximately 2:25 am with the earring from the first incident and 2 thumb tacks in her stomach. She was admitted to [name] Hospital. Conclusions: [Client A] did ingest an earring that she took from a roommate. She was transported to the hospital, treated, and released. 20 minutes after arriving she swallowed a thumb tack and became aggressive. 911 was called and she was transported back to the hospital for swallowing a tack." The investigation was not thorough as evidenced by: -There was no interview with the PS (Program Supervisor) who was present during the incidents on 1/23/24 and 1/24/24. -There was no interview with staff #2, #4 or #5 included in the investigation. -There was no interview with client A's roommate who witnessed her swallowing the earring. -There were no interviews with clients A, B, C, D, E, F or G in the investigation (or indicate if clients were present). -There was no review of client A's Behavior Support Plan in the investigation. -The investigation did not indicate whether or not staff #1, #3 or #6 implemented client A's BSP as written. -The investigation did not include recommendations for measures to prevent recurrence.			

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	Client A's record was reviewed on 2/19/24 at 3:20 PM. The last IDT (Interdisciplinary Team) note available for review dated 6/13/23 indicated the following: "...Behavior Management: She has improved on her behaviors by utilizing her coping skills, completing her classes and help staff with tasks...." Client A's Antecedent Behavior Data collection sheets indicated the following: -"8/13/23: Aggression Towards Self (looking to find sharp objects to cut herself with) Second Shift: used shampoo cap to harm her arm. Aggression To Others (Verbal aggression) frustrated and began yelling. Disruptive Behavior (screaming/yelling) yelling and slamming bedroom door, Uncooperative Behavior (Acted defiant) went to room and called family talking about staff Target Behavior Displayed: verbal aggression, yelling, hurting herself Replacement Behavior used: attempt to redirect attention, talked with staff, 15 minute checks started. Narrative of what occurred on our shift-give details about the incidents above specifically: [Client A] used shampoo bottle to hurt her arm through scrapping it roughness on her skin (sic). Wound was cleaned and ointment applied. She talked with staff and calmed down and put on 15 minute checks. She wanted staff to take her to the store to buy cigarettes after and I told her we could not but she had time to go on her own. [Client A] began yelling and went to her room and she had slammed the bedroom door. She also pressured her roommate to give her cigarettes to her to calm down so she will not have a behavior			

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	etc. House Manager was notified. Staff completing Note: [DSP #5]." -"11/03/23: Aggression to Others (verbal aggression). Marked 2 times on second shift. Disruptive Behavior (screaming/yelling). Marked 4 times on second shift. Uncooperative Behavior (Acts defiant). Marked 2 times on second shift. Target Behavior Displayed: yelling, throwing things, cussing, slamming doors Replacement Behavior used: blank Narrative of what occurred on our shift-give details about the incidents above specifically: Was mad about not having money on her and went to her room yelling and cussing at everyone. Slammed her bedroom door went outside slamming the doors (sic). Came back in and slammed the door. Came to dinner table and punched (the table) and took apart gaming stand. Throw (sic) parts of gaming stand at me. Went and turned around and throw everything off the thing behind her (sic). Went back out yelling and slamming the door. Staff completing Note: [DSP #3]." -"1/20/24: Aggression Towards Self (looking to find sharp objects to cut herself with). 1 marked on first shift and 1 marked on second shift...Disruptive Behavior (screaming/yelling, starts arguments). 1 marked at first shift and 1 marked for second shift. Target Behavior Displayed: Swallowed a tack to cause self-harm Replacement Behavior used: none Narrative of what occurred on our shift-give details about the incidents above specifically: Saturday, Jan. 20th [client A] came into the living room with [DSP #5], [DSP #1] and I and said, "I'm going to swallow this tack like my sister because I want to be just like her." She then put something			

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	in her mouth, then took a drink and appeared to swallow. Staff completing Note: [DSP #6]." -"1/23/24: Suicidal Behavior (Develops suicidal ideation). 1 time on Second Shift Target Behavior Displayed: Swallowed a tack to cause self-harm Replacement Behavior used: none Narrative of what occurred on our shift-give details about the incidents above specifically: Got mad at staff. Went to roommate (and) asked to see an earring. Told roommate she swallowed the earring. Roommate came to the office and told staff that she swallowed one of her earrings. Called 911. Emergency personnel came and talked to her. She told the (sic) she hopes she dies. Then she went with them (emergency personnel) to the E.R. (Emergency Room). Staff completing Note: [DSP #3]." -"1/24/24: Aggression Towards Self (looking to find sharp objects to cut herself with). Swallowed Thumb Tacks x 2 on Third Shift. Uncooperative Behavior (Acts defiant) x 6 on Third Shift, Suicidal Behavior (Develops suicidal ideation) x 4 on Third Shift. Target Behavior Displayed: Swallowed 2 thumb tacks Replacement Behavior used: none called 911 Narrative of what occurred on our shift-give details about the incidents above specifically: [client A] came back from the hospital. At 1:50 AM she found 2 thumb tacks she had hidden. She refused to follow direction and was be (sic) belligerent. She then said she swallowed a thumb tack, 2 minutes later she said she was going to swallow another one. This staff observed her putting something in her mouth and swallowed it with water. 911 was called. She then threatened her roommate with putting something in her water.			

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	Police showed up at 2:00 AM. The Ambulance showed up around 2:10 AM. After arguing with police and EMS they took her back to the hospital at approx. (approximately) 2:25 AM. She said she hopes she dies." Staff completing Note: [PS]." The Behavior Support Plan dated 9/20/23 indicated the following: "...Target Behavior One Definition: Aggression Toward Self is defined as, but not limited to, looking to find sharp objects to cut herself with. Proactive/Preventative Strategies: ·[Client A] usually engages in Aggression Towards Self whenever she thinks her twin sister is in trouble or something is wrong with her. The team has identified the following signs [client A] typically displays when she is upset: ·screaming, yelling, and crying · isolating herself from others (not talking) · refusing to eat · looking around really fast- like she is looking for something to potentially harm herself with · sitting alone in her room ·If [client A] is exhibiting any of the above behaviors or seems to be upset about something, ask her if she would like to talk about what is upsetting her. If she talks, listen and acknowledge her feelings. Do not tell her to 'get over it' or tell her she should not be upset, this will only escalate the behavior or cause another behavior to occur. · If [client A] does not want to talk, respect her wishes. Keep [client A] in line-of-sight but do not talk or touch her. Keep body language neutral. Give her time and space to calm down while ensuring her safety. You may also ask [client A] if she would like to watch her shape-breathing video. The video helps [client A] slow her breathing and calm down. · Monitor [client A's] environment for any sharp			

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	items she may use to harm herself. · Give [client A] verbal praise when she engages in a coping skill instead of engaging in Aggression Towards Self... Target Behavior Five Definition: Suicidal Behavior is defined as, but not limited to, develops suicidal ideation, and attempts to commit suicide... Proactive/Preventative Strategies: ·if [client A] seems upset about something, ask her if she would like to talk about what is bothering her. If she talks, listen and acknowledge her feelings. Do not ignore what she is saying. If possible, try to come up with a solution to her problem. ·If [client A] does not want to talk, suggest she calls her support person (friend, suicidal hotline, Behavior Consultant, boyfriend, or family member), if [client A] chooses to talk to her twin sister or a family member, staff will monitor the phone conversation due to her twin sister telling [client A] to commit suicide which in turn [client A] did attempt. Additionally, [client A's] father told her about her cat dying and laughed about it which in turn caused [client A] to attempt suicide. The phone conversation with her sister or a family member should be done in the common room so staff can try to intervene as quickly as possible if [client A's] mood worsens. ·If [client A] does not want to talk to her support person, try to engage her in a task or activity to get her mind off of whatever is bothering her. She enjoys helping a fellow peer with his chores, and helping around the house..." DSP #3 was interviewed on 2/19/24 at 2:13 PM. DSP #3 indicated client A talks to her sister on the phone multiple times a day. DSP #3 indicated if client A's sister has a behavior then client A would have a behavior. DSP #3 indicated client A			

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	would have arguments and smack her housemates. DSP #3 indicated behavior reports were completed. DSP #3 indicated she wasn't aware of the IDT (Interdisciplinary Team) meeting to discuss client A's behavioral needs. DSP #3 indicated client A went to her roommate and asked for an earring on 1/23/24, swallowed it and was taken to the hospital. DSP #3 indicated she picked up client A from the hospital when client A was discharged after swallowing the earring. DSP #3 indicated client A took a butter knife from the kitchen trying to open her closet, which was locked. DSP #3 indicated another housemate gave client A some thumb tacks not realizing she was intending to swallow them. DSP #3 indicated client A swallowed 2 thumb tacks in front of the PS. DSP #3 indicated client A wanted out of the group home and planned on swallowing things so she didn't have to come back. DSP #3 indicated client A is now living with her mother. DSP #3 was not sure if suicidal ideation was in client A's plan. DSP #3 indicated she would attempt to talk to client A regarding the consequences of swallowing harmful items. DSP #3 indicated client A told her she wanted to die because her sister wanted to die and their mother didn't care. DSP #3 indicated some of client A's behavior plans were effective and some were not. DSP #3 stated, "Staff talking to [client A] wasn't doing anything." DSP #3 indicated the PS would let staff know when client A needed to be checked on every 15 minutes after suicide attempts. The PS (Program Supervisor) was interviewed on 2/20/24 at 7:10 AM. The PS indicated when she became the program supervision one year ago, she began implementing the house rules and client A didn't want to follow the rules. The PS indicated client A smacked other clients and cursed. The PS indicated staff should have			

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	completed incident and behavior reports. The PS indicated the IDT has not met to discuss client A's behavior needs. The PS indicated client A used to have a behavior consultant, but she doesn't have one now. The PS indicated client A's BSP has not been revised. The PS indicated client A's behaviors have become more frequent in the last few months. The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 2/20/24 at 10:02 AM. The QIDP indicated the IDT should meet to revise the BSP as needed. The AD (Area Director) was interviewed 2/20/24 at 11:14 AM. The AD indicated client A would talk to her sister on the phone and copy the same harmful behaviors. The AD indicated client A's sister told her to swallow a tack. The AD indicated the staff would encourage client A to have healthy conversations with her sister, but she won't listen to their advice. The AD indicated client A refuses to be compliant. The AD indicated he was not aware of client A being aggressive toward other housemates or having significant behaviors prior to swallowing the thumb tacks. The AD indicated he met weekly with the PS to talk about strategies to handle situations but a formal meeting did not take place. The AD indicated the group home no longer has access to a behavior consultant and the behavior plans are now managed by the QIDP. The AD indicated when an incident requires investigation, the QI (Quality Improvement) department will send him a list of questions to ask of the witnesses. The AD indicated he did not interview any clients. The AD indicated he interviewed staff who told him what the client said. The AD indicated a summary of the report is sent to QI who will take over the investigation if needed. The			

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	15G763	A. BUILDING 00 B. WING	02/21/2024

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	AD indicated during the investigation he concludes if the plans were followed and the necessary individuals were contacted. The AD indicated he did not receive training to complete thorough investigations. The RN (Registered Nurse) was interviewed on 2/20/24 at 2:54 PM. The RN stated the IDT "has not met in awhile". The RN indicated multiple staff reported to her client A copies what her sister does. The RN indicated client A hurt herself with a bottle cap and swallowed tacks after her sister did the same thing. The RN indicated the PS reported client A's roommate was fearful of her. The BDS coordinator was interviewed on 2/20/24 at 3:58 PM. The BDS coordinator indicated client A has been having behavior issues on and off for the past year. The BDS coordinator indicated client A intended to sign herself out of the group home but has decided to remain a client on therapeutic leave until she gets a waiver. The BDS coordinator indicated she does not anticipate client A returning to the group home. DSP #3 was interviewed on 2/20/24 at 4:55 PM. DSP #3 stated, "Sometimes I got so busy, I forgot to make the (behavior) reports." DSP #3 indicated some of the other staff refuse to complete behavior reports. DSP #3 indicated client A would have a behavior a couple times a week. The facility's abuse and neglect policy was reviewed on 2/19/24 at 10:52 AM. The policy dated September 2017 indicated the following: "...Indiana MENTOR promotes a high quality of service and seeks to protect individuals receiving Indiana MENTOR services through oversight of management procedures and company operations, close monitoring of service delivery and through a			

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	process of identifying, evaluating and reducing risk to which individuals are exposed...Indiana MENTOR is committed to ensuring the individuals we serve are provided with a safe and quality living environment in order to ensure the highest standard of service delivery specific staff will be assigned to the monitoring and review of Quality Improvement. These staff will assist in providing Individual Support Teams with corporate supports, recommendations and resources for incident management and will review the effectiveness of the recommendations...The Area Director will complete an Incident Summary Report detailing the progress made towards meeting the recommendations previously set forth. The report may include further recommendations that may have been provided by the Interdisciplinary Team or outside agency involved in the resolution of the incident. This procedure will provide Indiana MENTOR with the information needed to ensure the effectiveness of the recommendations and an opportunity to make additional recommendations as needed... 1. Investigations will be completed for all deaths, allegations of abuse, neglect, exploitation or mistreatment. Additional investigations will be completed for incidents with significant injuries of unknown origin and incidents that may be requested by outside entities. 2. Investigations will be completed using the Indiana MENTOR Investigator Minimum Standards guidelines. 3. Investigation summary report will minimally include: a) Immediate safety measures put into place following event/alleged event b) Nature of the event/allegation c) A collection of all interviews, witness statements, pictures or any physical evidence			

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	d) Review of all information reviewed - e.g. daily support records, staff notes, medication administration records, behavior tracking or any other evidence reviewed e) Resolution of any discrepancies f) Summary of conclusion/findings to include when allegation of abuse, neglect or exploitation and whether allegation is substantiated or unsubstantiated. 4. All staff completing investigations will receive Indiana MENTOR core training for investigations... 7. Area Director will be notified via IMS (Incident Management System) of the completion of investigation by the investigator within 5 business days. 8. Response Action plans will be developed by Area Directors to address any action that needs to be taken in response to the incident and results of the investigation...." This federal tag relates to complaint #IN00426817. 9-3-2(a)			
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 3 sampled clients (A), the facility failed to thoroughly investigate incidents of SIB (Self-Injurious Behavior) resulting in emergency medical evaluation. Findings include: The facility's Bureau of Disabilities Services (BDS) reports, internal incident reports and investigations were reviewed on 2/19/24 at 11:40	W 0154	Area Director and Program Directors will be trained on completing investigations Area Director and Program Directors will be trained on completing any recommendations due to investigations Area Director and Program Directors will be trained on reporting all incidents to BDS within 24 hours of the incident	03/22/2024

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	AM and indicated the following: A) A BDS report dated 11/27/23 indicated the following: "Individual (client A) got a call from her sister and her sister told her that she had recently cut her arms. This individual called their mother and her mother asked her if she was going to cut herself too. Individual then took the back of of a video game, went to the bathroom, closed and blocked the door with her body, and then scraped her right arm with the back she had taken off. Police were notified and arrived. Individual was taken to the hospital. Plan to resolve: Staff will continue to follow the behavior plan and be supportive as needed." An investigation was not available for review for the BDS report dated 11/27/23. The AD (Area Director) was interviewed on 2/20/24 at 1:36 PM. The AD indicated the QI (Quality Improvement) department did not notify him to complete an investigation for the incident on 11/27/23. B) A BDS report dated 1/20/24 indicated the following: "[Client A] stated to staff that she swallowed a thumb tack around 9:10 pm EST. 911 was called. The police showed up before the ambulance and the ambulance got there 9:35 pm. She was transported to [name] Hospital where she was admitted, She is currently in hospital. Plan to resolve: Keep in contact with hospital, follow all discharge orders. All thumb tacks have been removed from the home." An investigation dated 1/24/24 indicated the following:		All staff will be trained on client rights and Abuse/Neglect Policy Program Supervisor will monitor 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, Regional Director	

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	"Incident Summary... Witnesses Interviewed including Job titles or relationship to the Network: [DSP (Direct Support Professional) #5], [DSP #1] and [DSP #6] Documents or Files reviewed: PCISP (Person Centered Individualized Support Plan), Hospital Discharge Paperwork... [Client A] stated to staff that she swallowed a thumb tack around 9:10 pm EST. 911 was called. The police showed up before the ambulance and the ambulance got there 9:35 pm. She was transported to [name] Hospital where she was admitted. She is currently in the hospital... Factual Findings [Client A] was on the phone with her sister and her sister told her that she swallowed a thumb tack and that she should do the same thing. [Client A] then found a thumb tack in the home. Staff witnessed [Client A] put something in her mouth and swallowed it. The staff stated that they were unsure if she put a tack in her mouth and swallowed it. However, because she stated that she did they immediately called 911 and had the individual transported to the hospital. All safety protocols were followed. There were no policy or procedure violations. Conclusions of Fact (i.e. Investigator's conclusions to the questions and issues initially raised by the incident) Individual was taken to the hospital and the hospital took an xray. Hospital stated item was not retrievable. Hospital discharged the individual with Miralax (constipation) and asked for the house to follow up with PCP (Primary Care Physician)." The investigation was not thorough as evidenced by:			

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	-The investigation did not include the number of staff present. -There was no interview with staff #2, #3, #4 or the PS (Program Supervisor) included in the investigation. -There were no interviews with clients A, B, C, D, E, F or G in the investigation (or indicate if clients were present). -There was no review of client A's BSP (Behavior Support Plan) in the investigation. -The investigation did not indicate whether or not staff #1, #5 or #6 implemented client A's BSP as written. -The investigation did not include recommendations for measures to prevent recurrence. C) A BDS report dated 1/23/24 indicated the following: "On 1/23/24 @ 9:50 pm EST [client A's] roommate came to the office and told us [client A] took one of her earrings and swallowed it. [Client A] was asked if she did in fact swallow an earring and she said yes. We then called 911, Police and Fire & Rescue showed up at 9:55 pm. After initially denying she swallowed the earring she finally admitted to it. She stated she hopes she dies. The ambulance arrived at 10:10 pm, they left with her at 10:20 pm and took her to [name] Hospital. They called at 12:05 am stating she was being discharged. Staff picedk (sic) her up. She arrived back at the group home at 1:30 am. At 1:50 am on 1/24/24. [Client A] came back from the hospital, 20 minutes later she was opening and closing her dresser drawers. Apparently she has (sic) thumb tacks hidden in one of them. She was being belligerent and refused to follow direction. She said she swallowed a thumb tack and 2 minutes later said she was going to swallow another one. I observed her putting something in her mouth and			

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	she swallowed it with water. 911 was called, she then went in and threatened her roommate with putting something in her water. The police showed up at 2:00 am and she argued with them. The ambulance showed up around 2:10 am. After arguing with police and EMS (Emergency Medical Services) they took her back to the hospital at approximately 2:25 am with the earring from the first Incident and 2 thumb tacks in her stomach. She was admitted to [name] Hospital. She is currently still there." An investigation dated 1/25/24-2/2/24 indicated the following: "...Witnesses Interviewed including Job titles or relationship to the Network: [DSP #3], [DSP #1] and [DSP #6] Documents or Files reviewed: PS (Program Supervisor) filed the Incident Report on the state portal as well. Program Director submitted the report on IMS (Incident Management System)... Factual Findings: [client A's] roommate came to the office and told us [client A] took one of her earrings and swallowed it. [Client A] was asked if she did in fact swallow an earring and she said yes. Next staff called 911, Police and Fire & Rescue showed up at 9:55 pm. After initially denying she swallowed the earring she finally admitted to it. She stated she hopes she dies. The ambulance arrived at 10:10 pm. They left with her at 10:20 pm and took her to [name] Hospital. They called at 12:05 am stating she was being discharged. Staff picked her up. 20 minutes later she was opening and closing her dresser drawers. She had thumb tacks hidden in one of them. She was being belligerent and refused to follow direction. She said she swallowed a thumb tack and 2 minutes later said she was going to swallow another one. Staff observed her putting something in her mouth and she swallowed it with			

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	water. 911 was called, she then went in and threatened her roommate with putting something in her water. The police showed up at 2:00 am and she argued with them. The ambulance showed up around 2:10 am. After arguing with police and EMS they took her back to the hospital at approximately 2:25 am with the earring from the first incident and 2 thumb tacks in her stomach. She was admitted to [name] Hospital. Conclusions: [Client A] did ingest an earring that she took from a roommate. She was transported to the hospital, treated, and released. 20 minutes after arriving she swallowed a thumb tack and became aggressive. 911 was called and she was transported back to the hospital for swallowing a tack." The investigation was not thorough as evidenced by: -There was no interview with the PS (Program Supervisor) who was present during the incidents on 1/23/24 and 1/24/24. -There was no interview with staff #2, #4 or #5 included in the investigation. -There was no interview with client A's roommate who witnessed her swallowing the earring. -There were no interviews with clients A, B, C, D, E, F or G in the investigation (or indicate if clients were present). -There was no review of client A's Behavior Support Plan in the investigation. -The investigation did not indicate whether or not staff #1, #3 or #6 implemented client A's BSP as written. -The investigation did not include recommendations for measures to prevent recurrence. The AD (Area Director) was interviewed 2/20/24			

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	at 11:14 AM. The AD indicated when an incident requires investigation, the QI department will send him a list of questions to ask of the witnesses. The AD indicated he did not interview any clients. The AD indicated he interviewed staff who told him what the client said. The AD indicated a summary of the report is sent to QI who will take over the investigation if needed. The AD indicated during the investigation he concludes if the plans were followed and the necessary individuals were contacted. The AD indicated he did not receive training to complete thorough investigations. This federal tag relates to complaint #IN00426817. 9-3-2(a)			
W 0156 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 1 of 3 sampled clients (A), the facility failed to ensure an incident of SIB (Self-Injurious Behavior) resulting in emergency medical evaluation was investigated within 5 working days. Findings include: The facility's Bureau of Disabilities Services (BDS) reports, internal incident reports and investigations were reviewed on 2/19/24 at 11:40 AM and indicated the following: A BDS report dated 1/23/24 indicated the following:	W 0156	Program Director and Area Director will be trained on incident reporting including but not limited to submitting all reportable incidents within 24 hours and completing investigations All staff will be trained on incident reporting All staff will be trained on Abuse and Neglect and Client Rights Program Supervisor will monitor at least three times weekly during home visits Program Director will	03/22/2024

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	"On 1/23/24 @ 9:50 pm EST [client A's] roommate came to the office and told us [client A] took one of her earrings and swallowed it. [Client A] was asked if she did in fact swallow an earring and she said yes. We then called 911, Police and Fire & Rescue showed up at 9:55 pm. After initially denying she swallowed the earring she finally admitted to it. She stated she hopes she dies. The ambulance arrived at 10:10 pm, they left with her at 10:20 pm and took her to [name] Hospital. They called at 12:05 am stating she was being discharged. Staff picedk (sic) her up. She arrived back at the group home at 1:30 am. At 1:50 am on 1/24/24, [Client A] came back from the hospital, 20 minutes later she was opening and closing her dresser drawers. Apparently she has (sic) thumb tacks hidden in one of them. She was being belligerent and refused to follow direction. She said she swallowed a thumb tack and 2 minutes later said she was going to swallow another one. I observed her putting something in her mouth and she swallowed it with water. 911 was called, she then went in and threatened her roommate with putting something in her water. The police showed up at 2:00 am and she argued with them. The ambulance showed up around 2:10 am. After arguing with police and EMS (Emergency Medical Services) they took her back to the hospital at approximately 2:25 am with the earring from the first Incident and 2 thumb tacks in her stomach. She was admitted to [name] Hospital. She is currently still there." An investigation dated 1/25/24-2/2/24 indicated the following: "...Witnesses Interviewed including Job titles or relationship to the Network: [DSP #3], [DSP #1] and [DSP #6] Documents or Files reviewed: PS (Program Supervisor) filed the Incident Report on the state		monitor and address any issues through weekly during Site Supervisory visits Persons Responsible: Area Director, Program Director, Program Supervisor, Regional Director	

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	portal as well. Program Director submitted the report on IMS (Incident Management System)... Factual Findings: [client A's] roommate came to the office and told us [client A] took one of her earrings and swallowed it. [Client A] was asked if she did in fact swallow an earring and she said yes. Next staff called 911, Police and Fire & Rescue showed up at 9:55 pm. After initially denying she swallowed the earring she finally admitted to it. She stated she hopes she dies. The ambulance arrived at 10:10 pm. They left with her at 10:20 pm and took her to [name] Hospital. They called at 12:05 am stating she was being discharged. Staff picked her up. 20 minutes later she was opening and closing her dresser drawers. She had thumb tacks hidden in one of them. She was being belligerent and refused to follow direction. She said she swallowed a thumb tack and 2 minutes later said she was going to swallow another one. Staff observed her putting something in her mouth and she swallowed it with water. 911 was called, she then went in and threatened her roommate with putting something in her water. The police showed up at 2:00 am and she argued with them. The ambulance showed up around 2:10 am. After arguing with police and EMS they took her back to the hospital at approximately 2:25 am with the earring from the first incident and 2 thumb tacks in her stomach. She was admitted to [name] Hospital. Conclusions: [Client A] did ingest an earring that she took from a roommate. She was transported to the hospital, treated, and released. 20 minutes after arriving she swallowed a thumb tack and became aggressive. 911 was called and she was transported back to the hospital for swallowing a tack." The QIDP (Qualified Intellectual Disabilities			

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	Professional) was interviewed on 2/19/24 at 10:23 AM. The QIDP indicated investigation should be completed within 5 days of the incident. The AD (Area Director) was interviewed on 2/20/24 at 11:14 AM. The AD indicated investigations should be completed within 5 days. This federal tag relates to complaint #IN00426817. 9-3-2(a)			
W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 1 of 3 sampled clients (A), the facility failed to develop and implement corrective measures prevent recurrence of client A swallowing unsafe objects. Findings include: The facility's Bureau of Disabilities Services (BDS) reports, internal incident reports and investigations were reviewed on 2/19/24 at 11:40 AM and indicated the following: A) A BDS report dated 11/27/23 indicated the following: "Individual got a call from her sister and her sister told her that she had recently cut her arms. This individual called their mother and her mother asked her if she was going to cut herself too. Individual then took the back of a video game, went to the bathroom, closed and blocked the door with her body, and then scraped her right arm with the back she had taken off. Police were notified and arrived. Individual was taken to the hospital. Plan to resolve: Staff will continue to	W 0157	Area Director and Program Directors will be trained on completing thorough investigations and implementing corrective actions as a result of the investigations All staff will be trained on client rights and Abuse/Neglect Policy All staff will be trained on incident reporting Program Supervisor will monitor 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, Regional Director	03/22/2024

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	follow the behavior plan and be supportive as needed." An investigation was not available for review for the BDS report dated 11/27/23. B) A BDS report dated 1/20/24 indicated the following: "[Client A] stated to staff that she swallowed a thumb tack around 9:10 pm EST. 911 was called. The police showed up before the ambulance and the ambulance got there 9:35 pm. She was transported to [name] Hospital where she was admitted, She is currently in hospital. Plan to resolve: Keep in contact with hospital, follow all discharge orders. All thumb tacks have been removed from the home." An investigation dated 1/24/24 indicated the following: "Incident Summary... Witnesses Interviewed including Job titles or relationship to the Network: [DSP (Direct Support Professional) #5], [DSP #1] and [DSP #6] Documents or Files reviewed: PCISP (Person Centered Individualized Support Plan), Hospital Discharge Paperwork... [Client A] stated to staff that she swallowed a thumb tack around 9:10 pm EST. 911 was called. The police showed up before the ambulance and the ambulance got there 9:35 pm. She was transported to [name] Hospital where she was admitted. She is currently in the hospital... Factual Findings [Client A] was on the phone with her sister and her sister told her that she swallowed a thumb tack and that she (client A) should do the same thing. [Client A] then found a thumb tack in the home. Staff witnessed [Client A] put something in			

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	15G763	A. BUILDING 00 B. WING	02/21/2024

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	her mouth and swallowed it. The staff stated that they were unsure if she put a tack in her mouth and swallowed it. However, because she stated that she did they immediately called 911 and had the individual transported to the hospital. All safety protocols were followed. There were no policy or procedure violations. Conclusions of Fact (i.e. Investigator's conclusions to the questions and issues initially raised by the incident) Individual was taken to the hospital and the hospital took an xray. Hospital stated item was not retrievable. Hospital discharged the individual with Miralax (constipation) and asked for the house to follow up with PCP (Primary Care Physician)." C) A BDS report dated 1/23/24 indicated the following: "On 1/23/24 @ 9:50 pm EST [client A's] roommate came to the office and told us [client A] took one of her earrings and swallowed it. [Client A] was asked if she did in fact swallow an earring and she said yes. We then called 911, Police and Fire & Rescue showed up at 9:55 pm. After initially denying she swallowed the earring she finally admitted to it. She stated she hopes she dies. The ambulance arrived at 10:10 pm, they left with her at 10:20 pm and took her to [name] Hospital. They called at 12:05 am stating she was being discharged. Staff picedk (sic) her up. She arrived back at the group home at 1:30 am. At 1:50 am on 1/24/24, [Client A] came back from the hospital, 20 minutes later she was opening and closing her dresser drawers. Apparently she has (sic) thumb tacks hidden in one of them. She was being belligerent and refused to follow direction. She said she swallowed a thumb tack and 2 minutes later said she was going to swallow another one. I			

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	15G763	A. BUILDING 00 B. WING	02/21/2024

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	observed her putting something in her mouth and she swallowed it with water. 911 was called, she then went in and threatened her roommate with putting something in her water. The police showed up at 2:00 am and she argued with them. The ambulance showed up around 2:10 am. After arguing with police and EMS (Emergency Medical Services) they took her back to the hospital at approximately 2:25 am with the earring from the first Incident and 2 thumb tacks in her stomach. She was admitted to [name] Hospital. She is currently still there." An investigation dated 1/25/24-2/2/24 indicated the following: "...Witnesses Interviewed including Job titles or relationship to the Network: [DSP #3], [DSP #1] and [DSP #6] Documents or Files reviewed: PS (Program Supervisor) filed the Incident Report on the state portal as well. Program Director submitted the report on IMS (Incident Management System)... Factual Findings: [client A's] roommate came to the office and told us [client A] took one of her earrings and swallowed it. [Client A] was asked if she did in fact swallow an earring and she said yes. Next staff called 911, Police and Fire & Rescue showed up at 9:55 pm. After initially denying she swallowed the earring she finally admitted to it. She stated she hopes she dies. The ambulance arrived at 10:10 pm. They left with her at 10:20 pm and took her to [name] Hospital. They called at 12:05 am stating she was being discharged. Staff picked her up. 20 minutes later she was opening and closing her dresser drawers. She had thumb tacks hidden in one of them. She was being belligerent and refused to follow direction. She said she swallowed a thumb tack and 2 minutes later said she was going to swallow another one. Staff observed her putting			

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	something in her mouth and she swallowed it with water. 911 was called, she then went in and threatened her roommate with putting something in her water. The police showed up at 2:00 am and she argued with them. The ambulance showed up around 2:10 am. After arguing with police and EMS they took her back to the hospital at approximately 2:25 am with the earring from the first incident and 2 thumb tacks in her stomach. She was admitted to [name] Hospital. Conclusions: [Client A] did ingest an earring that she took from a roommate. She was transported to the hospital, treated, and released. 20 minutes after arriving she swallowed a thumb tack and became aggressive. 911 was called and she was transported back to the hospital for swallowing a tack." The investigations did not include recommendations to prevent recurrence. The AD (Area Director) was interviewed on 2/20/24 at 11:14 AM. The AD indicated he is given a questionnaire to complete the investigation. The AD indicated he is only asked to provide the conclusion and findings. The AD indicated the form doesn't ask for recommendations. The AD indicated if further investigation is required the QI (Quality Improvement) department will take over. This federal tag relates to complaint #IN00426817. 9-3-2(a)			
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			

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	who- Based on record review and interview for 1 of 3 sampled clients (A), the QIDP (Qualified Intellectual Disabilities Professional) failed to integrate, coordinate and monitor client A's behavior support plan by failing to convene the IDT (Interdisciplinary Team) to address behavior support needs and ensure staff were completing behavior reports. Findings include: Client A's record was reviewed on 2/19/24 at 3:20 PM. The last IDT (Interdisciplinary Team) note available for review dated 6/13/23 indicated the following: "...Behavior Management: She has improved on her behaviors by utilizing her coping skills, completing her classes and help staff with tasks...." Additional IDT notes were not provided for review. Client A's Antecedent Behavior Data collection sheets indicated reports on the following dates: 8/13/23, 11/03/23, 1/20/24, 1/23/24 and 1/24/24. Additional behavior data was not available for review. DSP (Direct Support Staff) #3 was interviewed on 2/19/24 at 2:13 PM. DSP #3 indicated client A talks to her sister on the phone multiple times a day. DSP #3 indicated if client A's sister has a behavior then client A would have a behavior. DSP #3 indicated client A would have arguments and smack her housemates. DSP #3 indicated behavior reports were completed. DSP #3 indicated she	W 0159	Program Director and Area Director will be trained on procedures on updating BSPs including IDTs and Bi-Weekly meetings with State Clinical Director IDTs will be completed for each individual in the home to discuss all BSPs and if any changes will be needed All staff will be trained on individuals' BSPs including completing Behavior Reports Staff will be trained on incident reporting Program Supervisor will monitor at least three times weekly during home visits Program Director will monitor at least once weekly during Site Supervisor Visits Persons Responsible: Area Director, Program Director, Program Supervisor, Regional Director	03/22/2024

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	wasn't aware of the IDT (Interdisciplinary Team) meeting to discuss client A's behavioral needs. The PS (Program Supervisor) was interviewed on 2/20/24 at 7:10 AM. The PS indicated client A smacked other clients and cursed. The PS indicated staff should have completed incident and behavior reports. The PS indicated the IDT has not met to discuss client A's behavior needs. The PS indicated client A's BSP has not been revised. The PS indicated client A's behaviors have become more frequent in the last few months. The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 2/20/24 at 10:02 AM. The QIDP indicated the IDT should meet to revise the BSP as needed. The AD (Area Director) was interviewed 2/20/24 at 11:14 AM. The AD indicated he was not aware of client A being aggressive toward other housemates or having significant behaviors prior to swallowing the thumb tacks. The AD indicated if client A was being aggressive toward her housemates he would expect to see incident reports and behavior reports. The AD indicated he met weekly with the PS to talk about strategies to handle situations but a formal meeting did not take place. The AD indicated the group home no longer has access to a behavior consultant and the behavior plans are now managed by the QIDP. The RN (Registered Nurse) was interviewed on 2/20/24 at 2:54 PM. The RN stated the IDT "has not met in awhile". The RN indicated the PS reported client A's roommate was fearful of her. DSP #3 was interviewed on 2/20/24 at 4:55 PM. DSP #3 stated, "Sometimes I got so busy, I forgot			

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	to make the (behavior) reports." DSP #3 indicated client A would have a behavior a couple times a week. This federal tag relates to complaint #IN00426817. 9-3-3(a)			
W 0164 Bldg. 00	483.430(b)(1) PROFESSIONAL PROGRAM SERVICES Each client must receive the professional program services needed to implement the active treatment program defined by each client's individual program plan. Based on record review and interview for 1 of 3 sampled clients (A), the facility failed to provide a Behavior Consultant (BC) to address client A's SIB (Self-Injurious Behavior). Findings include: The facility's Bureau of Disabilities Services (BDS) reports, internal incident reports and investigations were reviewed on 2/19/24 at 11:40 AM and indicated the following: A) A BDS report dated 11/27/23 indicated the following: "Individual got a call from her sister and her sister told her that she had recently cut her arms. This individual called their mother and her mother asked her if she was going to cut herself too. Individual then took the back of a video game, went to the bathroom, closed and blocked the door with her body, and then scraped her right arm with the back she had taken off. Police were notified and arrived. Individual was taken to the hospital. Plan to resolve: Staff will continue to follow the behavior plan and be supportive as needed."	W 0164	Program Director and Area Director will be trained on procedures on updating BSPs including IDTs and Bi-Weekly meetings with State Clinical Director IDTs will be completed for each individual in the home to discuss all BSPs and if any changes will be needed All staff will be trained on individuals' BSPs including completing Behavior Reports Program Supervisor will monitor at least three times weekly during home visits Program Director will monitor at least once weekly during Site Supervisor Visits Persons Responsible: Area Director, Program Director, Program Supervisor, Regional Director	03/22/2024

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	B) A BDS report dated 1/20/24 indicated the following: "[Client A] stated to staff that she swallowed a thumb tack around 9:10 pm EST. 911 was called. The police showed up before the ambulance and the ambulance got there 9:35 pm. She was transported to [name] Hospital where she was admitted, She is currently in hospital. Plan to resolve: Keep in contact with hospital, follow all discharge orders. All thumb tacks have been removed from the home." C) A BDS report dated 1/23/24 indicated the following: "On 1/23/24 @ 9:50 pm EST [client A's] roommate came to the office and told us [client A] took one of her earrings and swallowed it. [Client A] was asked if she did in fact swallow an earring and she said yes. We then called 911, Police and Fire & Rescue showed up at 9:55 pm. After initially denying she swallowed the earring she finally admitted to it. She stated she hopes she dies. The ambulance arrived at 10:10 pm, they left with her at 10:20 pm and took her to [name] Hospital. They called at 12:05 am stating she was being discharged. Staff picedk (sic) her up. She arrived back at the group home at 1:30 am. At 1:50 am on 1/24/24, [Client A] came back from the hospital, 20 minutes later she was opening and closing her dresser drawers. Apparently she has (sic) thumb tacks hidden in one of them. She was being belligerent and refused to follow direction. She said she swallowed a thumb tack and 2 minutes later said she was going to swallow another one. I observed her putting something in her mouth and she swallowed it with water. 911 was called, she then went in and threatened her roommate with putting something in her water. The police showed up at 2:00 am and she argued with them.			

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	The ambulance showed up around 2:10 am. After arguing with police and EMS (Emergency Medical Services) they took her back to the hospital at approximately 2:25 am with the earring from the first Incident and 2 thumb tacks in her stomach. She was admitted to [name] Hospital. She is currently still there." Client A's record was reviewed on 2/19/24 at 3:20 PM. Client A's Antecedent Behavior Data collection sheets indicated the following: -"8/13/23: Aggression Towards Self (looking to find sharp objects to cut herself with) Second Shift: used shampoo cap to harm her arm. Aggression To Others (Verbal aggression) frustrated and began yelling. Disruptive Behavior (screaming/yelling) yelling and slamming bedroom door, Uncooperative Behavior (Acted defiant) went to room and called family talking about staff Target Behavior Displayed: verbal aggression, yelling, hurting herself Replacement Behavior used: attempt to redirect attention, talked with staff, 15 minute checks started. Narrative of what occurred on our shift-give details about the incidents above specifically: [Client A] used shampoo bottle to hurt her arm through scrapping it roughness on her skin (sic). Wound was cleaned and ointment applied. She talked with staff and calmed down and put on 15 minute checks. She wanted staff to take her to the store to buy cigarettes after and I told her we could not but she had time to go on her own. [Client A] began yelling and went to her room and she had slammed the bedroom door. She also pressured her roommate to give her cigarettes to her to calm down so she will not have a behavior			

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	etc. House Manager was notified. Staff completing Note: [DSP #5]." -"11/03/23: Aggression to Others (verbal aggression). Marked 2 times on second shift. Disruptive Behavior (screaming/yelling). Marked 4 times on second shift. Uncooperative Behavior (Acts defiant). Marked 2 times on second shift. Target Behavior Displayed: yelling, throwing things, cussing, slamming doors Replacement Behavior used: blank Narrative of what occurred on our shift-give details about the incidents above specifically: Was mad about not having money on her and went to her room yelling and cussing at everyone. Slammed her bedroom door went outside slamming the doors (sic). Came back in and slammed the door. Came to dinner table and punched (the table) and took apart gaming stand. Throw (sic) parts of gaming stand at me. Went and turned around and throw everything off the thing behind her (sic). Went back out yelling and slamming the door. Staff completing Note: [DSP #3]." -"1/20/24: Aggression Towards Self (looking to find sharp objects to cut herself with). 1 marked on first shift and 1 marked on second shift...Disruptive Behavior (screaming/yelling, starts arguments). 1 marked at first shift and 1 marked for second shift. Target Behavior Displayed: Swallowed a tack to cause self-harm Replacement Behavior used: none Narrative of what occurred on our shift-give details about the incidents above specifically: Saturday, Jan. 20th [client A] came into the living room with [DSP (Direct Support Professional) #5], [DSP #1] and I and said, "I'm going to swallow this tack like my sister because I want to be just			

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	like her." She then put something in her mouth, then took a drink and appeared to swallow. Staff completing Note: [DSP #6]." -"1/23/24: Suicidal Behavior (Develops suicidal ideation). 1 time on Second Shift Target Behavior Displayed: Swallowed a tack to cause self-harm Replacement Behavior used: none Narrative of what occurred on our shift-give details about the incidents above specifically: Got mad at staff. Went to roommate asked to see an earring. Told roommate she swallowed the earring. Roommate came to the office and told staff that she swallowed one of her earrings. Called 911. Emergency personnel came and talked to her. She told the (sic) she hopes she dies. Then she went with them (emergency personnel) to the E.R. (Emergency Room). Staff completing Note: [DSP #3]." -"1/24/24: Aggression Towards Self (looking to find sharp objects to cut herself with). Swallowed Thumb Tacks x 2 on Third Shift. Uncooperative Behavior (Acts defiant) x 6 on Third Shift, Suicidal Behavior (Develops suicidal ideation) x 4 on Third Shift. Target Behavior Displayed: Swallowed 2 thumb tacks Replacement Behavior used: none called 911 Narrative of what occurred on our shift-give details about the incidents above specifically: [client A] came back from the hospital. At 1:50 AM she found 2 thumb tacks she had hidden. She refused to follow direction and was be (sic) belligerent. She then said she swallowed a thumb tack, 2 minutes later she said she was going to swallow another one. This staff observed her putting something in her mouth and swallowed it with water. 911 was called. She then threatened			

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	her roommate with putting something in her water. Police showed up at 2:00 AM. The Ambulance showed up around 2:10 AM. After arguing with police and EMS they took her back to the hospital at approx. (approximately) 2:25 AM. She said she hopes she dies." Staff completing Note: [PS]." The Behavior Support Plan dated 9/20/23 indicated the following: "...Target Behavior One Definition: Aggression Toward Self is defined as, but not limited to, looking to find sharp objects to cut herself with. Proactive/Preventative Strategies: · [Client A] usually engages in Aggression Towards Self whenever she thinks her twin sister is in trouble or something is wrong with her. The team has identified the following signs [client A] typically displays when she is upset: ·screaming, yelling, and crying ·isolating herself from others (not talking) · refusing to eat · looking around really fast- like she is looking for something to potentially harm herself with · sitting alone in her room · If [client A] is exhibiting any of the above behaviors or seems to be upset about something, ask her if she would like to talk about what is upsetting her. If she talks, listen and acknowledge her feelings. Do not tell her to 'get over it' or tell her she should not be upset, this will only escalate the behavior or cause another behavior to occur. · If [client A] does not want to talk, respect her wishes. Keep [client A] in line-of-sight but do not talk or touch her. Keep body language neutral. Give her time and space to calm down while ensuring her safety. You may also ask [client A] if she would like to watch her shape-breathing video. The video helps [client A] slow her breathing and calm down.			

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	·Monitor [client A's] environment for any sharp items she may use to harm herself. ·Give [client A] verbal praise when she engages in a coping skill instead of engaging in Aggression Towards Self... Target Behavior Five Definition: Suicidal Behavior is defined as, but not limited to, develops suicidal ideation, and attempts to commit suicide... Proactive/Preventative Strategies: · if [client A] seems upset about something, ask her if she would like to talk about what is bothering her. If she talks, listen and acknowledge her feelings. Do not ignore what she is saying. If possible, try to come up with a solution to her problem. · If [client A] does not want to talk, suggest she calls her support person (friend, suicidal hotline, Behavior Consultant, boyfriend, or family member), if [client A] chooses to talk to her twin sister or a family member, staff will monitor the phone conversation due to her twin sister telling [client A] to commit suicide which in turn [client A] did attempt. Additionally, [client A's] father told her about her cat dying and laughed about it which in turn caused [client A] to attempt suicide. The phone conversation with her sister or a family member should be done in the common room so staff can try to intervene as quickly as possible if [client A's] mood worsens. ·If [client A] does not want to talk to her support person, try to engage her in a task or activity to get her mind off of whatever is bothering her. She enjoys helping a fellow peer with his chores, and helping around the house..." The PS (Program Supervisor) was interviewed on 2/20/24 at 7:10 AM. The PS indicated client A used to have a behavior consultant, but she doesn't have one now. The PS indicated client A's			

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	15G763	A. BUILDING 00 B. WING	02/21/2024

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TRANSITIONAL SERVICES SUB LLC	114 S CHESTNUT ST HUNTINGBURG, IN 47542

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	BSP has not been revised. The PS indicated client A's behaviors have become more frequent in the last few months. The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 2/20/24 at 10:02 AM. The QIDP indicated the IDT should meet to revise the BSP as needed. The QIDP indicated she started in January and began looking at the plan last week. The AD (Area Director) was interviewed 2/20/24 at 11:14 AM. The AD indicated the group home no longer has access to a behavior consultant and the behavior plans are now managed by the QIDP. The AD indicated client A would benefit from a behavior consultant. This federal tag relates to complaint #IN00426817. 9-3-3(a)			
W 0189 Bldg. 00	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based on record review and interview for 1 of 3 sampled clients (A), the facility failed to train staff on the components of a thorough investigation. Findings include: The facility's Bureau of Disabilities Services (BDS) reports, internal incident reports and investigations were reviewed on 2/19/24 at 11:40 AM and indicated the following: A) An investigation dated 1/24/24 indicated the	W 0189	Area Director and Program Directors will be trained on completing investigations Area Director and Program Directors will be trained on completing any recommendations due to investigations Area Director and Program Directors will be trained on reporting all incidents to BDS within 24 hours of the incident All staff will be trained on	03/22/2024

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	following: "Incident Summary... Witnesses Interviewed including Job titles or relationship to the Network: [DSP (Direct Support Professional) #5], [DSP #1] and [DSP #6] Documents or Files reviewed: PCISP (Person Centered Individualized Support Plan), Hospital Discharge Paperwork... [Client A] stated to staff that she swallowed a thumb tack around 9:10 pm EST. 911 was called. The police showed up before the ambulance and the ambulance got there 9:35 pm. She was transported to [name] Hospital where she was admitted. She is currently in the hospital... Factual Findings [Client A] was on the phone with her sister and her sister told her that she swallowed a thumb tack and that she should do the same thing. [Client A] then found a thumb tack in the home. Staff witnessed [Client A] put something in her mouth and swallowed it. The staff stated that they were unsure if she put a tack in her mouth and swallowed it. However, because she stated that she did they immediately called 911 and had the individual transported to the hospital. All safety protocols were followed. There were no policy or procedure violations. Conclusions of Fact (i.e. Investigator's conclusions to the questions and issues initially raised by the incident) Individual was taken to the hospital and the hospital took an xray. Hospital stated item was not retrievable. Hospital discharged the individual with Miralax (constipation) and asked for the house to follow up with PCP (Primary Care Physician)." The investigation was not thorough as evidenced		client rights and Abuse/Neglect Policy Program Supervisor will monitor 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, Regional Director	

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	by: -The investigation did not include the number of staff present. -There was no interview with staff #2, #3, #4 or the PS (Program Supervisor) included in the investigation. -There were no interviews with clients A, B, C, D, E, F or G in the investigation (or indicate if clients were present). -There was no review of client A's BSP (Behavior Support Plan) in the investigation. -The investigation did not indicate whether or not staff #1, #5 or #6 implemented client A's BSP as written. -The investigation did not include recommendations for measures to prevent recurrence. B) An investigation dated 1/25/24-2/2/24 indicated the following: "...Witnesses Interviewed including Job titles or relationship to the Network: [DSP #3], [DSP #1] and [DSP #6] Documents or Files reviewed: PS (Program Supervisor) filed the Incident Report on the state portal as well. Program Director submitted the report on IMS (Incident Management System)... Factual Findings: [client A's] roommate came to the office and told us [client A] took one of her earrings and swallowed it. [Client A] was asked if she did in fact swallow an earring and she said yes. Next staff called 911, Police and Fire & Rescue showed up at 9:55 pm. After initially denying she swallowed the earring she finally admitted to it. She stated she hopes she dies. The ambulance arrived at 10:10 pm. They left with her at 10:20 pm and took her to [name] Hospital. They called at 12:05 am stating she was being discharged. Staff picked her up. 20 minutes later she was opening and closing her dresser drawers.			

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	She had thumb tacks hidden in one of them. She was being belligerent and refused to follow direction. She said she swallowed a thumb tack and 2 minutes later said she was going to swallow another one. Staff observed her putting something in her mouth and she swallowed it with water. 911 was called, she then went in and threatened her roommate with putting something in her water. The police showed up at 2:00 am and she argued with them. The ambulance showed up around 2:10 am. After arguing with police and EMS they took her back to the hospital at approximately 2:25 am with the earring from the first incident and 2 thumb tacks in her stomach. She was admitted to [name] Hospital. Conclusions: [Client A] did ingest an earring that she took from a roommate. She was transported to the hospital, treated, and released. 20 minutes after arriving she swallowed a thumb tack and became aggressive. 911 was called and she was transported back to the hospital for swallowing a tack." The investigation was not thorough as evidenced by: -There was no interview with the PS (Program Supervisor) who was present during the incidents on 1/23/24 and 1/24/24. -There was no interview with staff #2, #4 or #5 included in the investigation. -There was no interview with client A's roommate who witnessed her swallowing the earring. -There were no interviews with clients A, B, C, D, E, F or G in the investigation (or indicate if clients were present). -There was no review of client A's Behavior Support Plan in the investigation. -The investigation did not indicate whether or not staff #1, #5 or #6 implemented client A's BSP as			

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	written. -The investigation did not include recommendations for measures to prevent recurrence. The AD (Area Director) was interviewed 2/20/24 at 11:14 AM. The AD indicated when an incident requires investigation, the QI (Quality Improvement) department will send him a list of questions to ask of the witnesses. The AD indicated he did not interview any clients. The AD indicated he interviewed staff who told him what the client said. The AD indicated a summary of the report is sent to QI who will take over the investigation if needed. The AD indicated during the investigation he concludes if the plans were followed and the necessary individuals were contacted. The AD indicated he did not receive training to complete thorough investigations. The facility's abuse and neglect policy was reviewed on 2/19/24 at 10:52 AM. The policy dated September 2017 indicated the following: "...Indiana MENTOR promotes a high quality of service and seeks to protect individuals receiving Indiana MENTOR services through oversight of management procedures and company operations, close monitoring of service delivery and through a process of identifying, evaluating and reducing risk to which individuals are exposed... 4. All staff completing investigations will receive Indiana MENTOR core training for investigations...." This federal tag relates to complaint #IN00426817. 9-3-3(a)			

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W 0240 Bldg. 00	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on record review and interview for 1 of 3 sampled clients (A), the facility failed to ensure client A's BSP (Behavior Support Plan) addressed her behavioral needs. Findings include: The facility's Bureau of Disabilities Services (BDS) reports, internal incident reports and investigations were reviewed on 2/19/24 at 11:40 AM and indicated the following: A) A BDS report dated 11/27/23 indicated the following: "Individual (client A) got a call from her sister and her sister told her that she had recently cut her arms. This individual called their mother and her mother asked her if she was going to cut herself too. Individual then took the back of of a video game, went to the bathroom, closed and blocked the door with her body, and then scraped her right arm with the back she had taken off. Police were notified and arrived. Individual was taken to the hospital. Plan to resolve: Staff will continue to follow the behavior plan and be supportive as needed." B) A BDS report dated 1/20/24 indicated the following: "[Client A] stated to staff that she swallowed a thumb tack around 9:10 pm EST. 911 was called. The police showed up before the ambulance and the ambulance got there 9:35 pm. She was transported to [name] Hospital where she was admitted, She is currently in hospital. Plan to	W 0240	Area Director and Program Director will be trained on updating BSPs and completing IDTs when needed Program Director and Area Director will be trained on procedures on updating BSPs including IDTs and Bi-Weekly meetings with State Clinical Director IDTs will be completed for each individual in the home to discuss all BSPs and if any changes will be needed All staff will be trained on individuals' BSPs including completing Behavior Reports Program Supervisor will monitor 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	03/22/2024

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	resolve: Keep in contact with hospital, follow all discharge orders. All thumb tacks have been removed from the home." C) A BDS report dated 1/23/24 indicated the following: "On 1/23/24 @ 9:50 pm EST [client A's] roommate came to the office and told us [client A] took one of her earrings and swallowed it. [Client A] was asked if she did in fact swallow an earring and she said yes. We then called 911, Police and Fire & Rescue showed up at 9:55 pm. After initially denying she swallowed the earring she finally admitted to it. She stated she hopes she dies. The ambulance arrived at 10:10 pm, they left with her at 10:20 pm and took her to [name] Hospital. They called at 12:05 am stating she was being discharged. Staff picedk (sic) her up. She arrived back at the group home at 1:30 am. At 1:50 am on 1/24/24. [Client A] came back from the hospital, 20 minutes later she was opening and closing her dresser drawers. Apparently she has (sic) thumb tacks hidden in one of them. She was being belligerent and refused to follow direction. She said she swallowed a thumb tack and 2 minutes later said she was going to swallow another one. I observed her putting something in her mouth and she swallowed it with water. 911 was called, she then went in and threatened her roommate with putting something in her water. The police showed up at 2:00 am and she argued with them. The ambulance showed up around 2:10 am. After arguing with police and EMS (Emergency Medical Services) they took her back to the hospital at approximately 2:25 am with the earring from the first Incident and 2 thumb tacks in her stomach. She was admitted to [name] Hospital. She is currently still there." Client A's record was reviewed on 2/19/24 at 3:20			

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	PM. The (BSP) Behavior Support Plan dated 9/20/23 indicated the following: "...Target Behavior One Definition: Aggression Toward Self is defined as, but not limited to, looking to find sharp objects to cut herself with. Target Behavior Five Definition: Suicidal Behavior is defined as, but not limited to, develops suicidal ideation, and attempts to commit suicide... Proactive/Preventative Strategies..." Client A's BSP did not include her recent behavior of swallowing an earring and tacks. DSP (Direct Support Professional) #3 was interviewed on 2/19/24 at 2:13 PM. DSP #3 indicated some of client A's behavior plans were effective and some were not. DSP #3 stated, "Staff talking to [client A] wasn't doing anything." DSP #3 indicated the PS would let staff know when client A need to be checked on every 15 minutes after suicide attempts. The PS (Program Supervisor) was interviewed on 2/20/24 at 7:10 AM. The PS indicated client A's BSP has not been revised. The PS indicated client A's behaviors have become more frequent in the last few months. The AD (Area Director) was interviewed 2/20/24 at 11:14 AM. The AD indicated client A's plan needs to be revised. The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 2/20/24 at 10:02 AM. The QIDP indicated the IDT (Interdisciplinary Team) should meet to revise the BSP as needed. The QIDP indicated swallowing			

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	tacks or other items should be part of client A's plan. This federal tag relates to complaint #IN00426817. 9-3-4(a)			