CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED 03/13/2023	
		15G300	B. WI	NG			
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP COD 110 W PIKE ST MARTINSVILLE, IN 46151				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		I	(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			COMPLETION
TAG	·	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
W 0000							
Bldg. 00			W 0	0000			
	Certification Revis	onjunction to the Post it (PCR) to the PCR completed stigation of complaint pleted on 8/11/22.					
		onjunction to the PCR to the mplaint #IN00391340 completed					
	Survey dates: February 13, 2023.	uary 28, March 1, 2, 3, 6, 7 and					
	Facility Number: 0 Provider Number: AIM Number: 100	15G300					
	accordance with 46	also reflect state findings in 50 IAC 9. this report completed by #15068					
W 0104	483.410(a)(1) GOVERNING BC	DDY					
Bldg. 00	The governing bo policy, budget, an the facility.	dy must exercise general ad operating direction over					
	clients living in the and H), the facility exercise operating failing to ensure the	view and interview for 8 of 8 group home (A, B, C, D, E, F, G 's governing body failed to direction over the facility by ere were policies and to ensure the group home	WO	0104	The operation is in the process of hiring an Office Coordinator who is responsible employee files being current Area Director and Progr Directors will be trained on		04/28/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

staff's driver licenses remained valid.

TITLE (X6) DATE

ensuring employee files are up to date when an Office Coordinator is

Bret Beauchamp Regional Director 04/27/2023

Any defiency statement 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 disclodays 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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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G300		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 03/13/2023	
	PROVIDER OR SUPPLIER		110 W	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: On 2/28/23 at 3:00 conducted and indictiver's license in the copy of a driver's lists aff #3's file had a expired on 4/8/2022 staff had a valid driver's license in the copy of a driver's license described and a valid driver's license to annually to ensure the indicated it was the report issues with the expired or suspender facility did not conducted the suspender facility did not conducted the coordinator of the factor of the f	PM, a review of staff files was cated 2 staff had an expired heir file. Staff #1's file had a cense that expired 6/11/2018. copy of a driver's license that 2. The facility did not ensure the ver's license on file. This 3, C, D, E, F, G and H. AM, the Area Supervisor (AD) he AD indicated staff driving hecked upon hire and then hey remain valid. The AD responsibility of the staff to heir licenses such as being ed. The AD indicated the duct motor vehicle checks after a AD indicated there has been for to assist with employee to stated, "we haven't had an for over 6 months." The AD lid driver's license "should be and "there should be a policy AM, the Qualified Intellectual ional (QIDP)/Program Manager staff should not be driving the they do not have a current e QIDP/PM stated proof of a e "should be maintained in the stor (RD) was interviewed on a transfer of the RD indicated the facility ing staff Bureau of Motor e RD stated employees "should a license in their employee file."		not present - An audit of employee will be conducted to ensure the all items are current - Once an Office Coord is hired, a tracking sheet will put into place to track all employees files to monitor at expirations that can be addressin a timely manner Persons Responsible: Area Director, Program Director, Coordinator	files hat inator be ny essed

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G300		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 03/13/2023			
	ROVIDER OR SUPPLIER		110 W	ADDRESS, CITY, STATE, ZIP COD PIKE ST INSVILLE, IN 46151	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
W 0120 Bldg. 00	Supervised Group I was reviewed on 3/indicated, "Staff Sci Indiana MENTOR squalified applicants basis of their skills, and enthusiasm4. the transportation of license check and vobtained and documpersonnel file" Trindicating how the staffs' driver lice throughout their em 9-3-1(a) 483.410(d)(3) SERVICES PROV SOURCES The facility must a meet the needs of Based on observation interview for 3 of 3 C) and 2 additional failed to ensure ther system in place between facility-operated day. Findings include: Observations were con 3/1/23 from 10:010:15 AM a request communication bood Day Program Super locate the group hor	on, record review and clients in the sample (A, B and clients (G and H), the facility e was a communication ween the group home and the	W 0120	- Home staff will be train on completing the communications and ensuring it is taken to Day Program daily - Day Program daily - Day Program staff will trained on completing communication book - Program Supervisor with monitor at least three times poweek during home visits - Day Program Director monitor daily at day program to ensure the communication bo present and completed correct - Program Director will monitor at least once weekly	ation to be lill er will to ook is

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G300		A. BUILDING <u>00</u> COMPLE		(X3) DATE SURVEY COMPLETED 03/13/2023	
	ROVIDER OR SUPPLIER		110 W I	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	book daily, it's an ir	e group home should bring the nportant communication tool."		during Site Supervisory Visits	
	Staff #6 indicated a to communicate wit program. Staff #6 st is a struggle" and "v it to the day program out." This affected of	PM staff #6 was interviewed. communication book is used the the facility-operated day stated "the communication book when we do remember to take m, they are horrible at filling it clients A, B, C, G and H. M, the Program Director (PD)		Persons Responsible: Area Director, Program Director, Da Program Director, Program Supervisor	ау
	indicated the group communication boo	home staff did not bring the k on this date. The PD vas supposed to use the			
W 0125 Bldg. 00	The facility must e clients. Therefore encourage individurights as clients of citizens of the Unit	CLIENTS RIGHTS consure the rights of all the facility must allow and the facility and as the facility, and as ted States, including the tints, and the right to due			
	Based on observation interview for 8 of 8 G and H) living in t	on, record review and clients (clients A, B, C, D, E, F, the group home, the facility door alarm was not intrusively	W 0125	The alarm company will be contacted to see if the speake volume can be controlled on the alarm or replaced with a speake with a lower volume - If the alarm company cannot provide a solution, a contracted be contacted to see if the volume	he k or will
	on 2/28/23 from 4:4 3/1/23 from 6:30 A	conducted in the group home 15 PM until 7:45 PM and on M through 9:10 AM. On 2/28/23 A, B, C, D, E, F, G and H arrived		can be decreased without disrupting the alarm system -Area Director and Program Director will ensure that alarm	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G300		A. BUILDING <u>00</u> COMI		(X3) DATE SURVEY COMPLETED 03/13/2023			
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD			
	TIONAL SERVICES		110 W PIKE ST MARTINSVILLE, IN 46151				
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION			
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE COMPLETION DATE		
		program, entered the home		company is contacted			
	_	or, and the door alarm		-All staff will be trained on clie	ent		
		loud noise. At 4:55 PM a front door, Direct Support		rights -Program director will monitor	con		
	•	#2 opened the door and the		home improvements during w			
		in a piercing loud manner. At		Site Supervisory vists			
		ied Intellectual Disabilities					
	, ,) entered the home from the		Persons Responsible: Area			
		sounded a piercing loud clients B and H left the home		Director, Program Director, Program Supervisor			
		outing through the back door,		Program Supervisor			
		led with a piercing loud noise.					
	When clients B and H returned to the home, the						
	side door alarm sounded with a piercing loud						
		he side door was exited, the					
	alarm sounded with	a piercing loud noise.					
	On 3/1/23 at 6:30 A	M, upon entering the home					
		or the alarm sounded with a					
		At 8:45 AM when clients A,					
		d H exited the home from the					
	_	o the day program, the alarm					
		cing loud noise. At 9:10 AM me from the side door, the					
	-	a piercing loud noise.					
		s conducted on 3/1/23 at 1:00					
		havior Support Plan (BSP)					
		BSP indicated, "Elopement: are alarms on the doors 24					
		tify staff if [client A] attempts					
	to leave the group h	• • • • • •					
		s conducted on 3/1/23 at 2:00					
		P dated 1/17/23. The BSP					
	_	ent: Door alarms- there are					
		24 hours per day to notify tempts to leave the group					
	home."	ompo to teave the group					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 03/13/2023		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 110 W PIKE ST MARTINSVILLE, IN 46151				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	PM of client C's BS indicated, "Elopeme alarms on the doors staff if [client C] att home." An interview was compared to be loud so stath home." An interview was compared to be loud so stath home." An interview was compared to be alarms cannot be "We have had the alarms cannot level, but	s conducted on 3/1/23 at 3:00 P dated 1/17/23. The BSP ent: Door alarms- there are 24 hours per day to notify empts to leave the group onducted on 3/7/23 at 10:00 The QIDP stated, "The alarm off can hear it anywhere in the onducted on 3/7/23 at 10:00 area Director). The AD stated, the loud, they are hard wired so the removed." The AD stated, larm company look at lowering there is no way to do that. the in to something else."					
W 0149 Bldg. 00	written policies an mistreatment, neg Based on interview sampled clients (client additional clients (client facility failed to improcedures to thorough allegation of staff reinvestigate, develop corrective measures elopements. Findings include:	evelop and implement d procedures that prohibit lect or abuse of the client. and record review for 3 of 3 ents A, B and C), plus 5 lients D, E, F, G and H), the olement its written policies and	W 0149	- Program Director and Director will be trained on incireporting and investigations was pecific outcome of investigations and investigations outcome of investigations of the control of t	dent vith a ions t st on on		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X:			X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		15G300	B. W	'ING		03/13/	2023
				CTREET	ADDRESS OF A STATE SID COD		
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
TDANIOIT	TIONIAL OFFICIOFO	CLIPILLO			PIKE ST		
TRANSII	TIONAL SERVICES	SUB LLC		MARIII	NSVILLE, IN 46151		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Disabilities Service	s (BDDS) reports were			- Program Supervisor wi	II	
	reviewed on 2/28/23	3 at 12:30 PM. The review			monitor and address any issue	es	
	indicated the follow	ving:			during home visits at least thre	ее	
					times per week		
	A BDDS report date	ed 11/17/22 at 12:56 AM			- Program Director will		
	indicated, "On 11/1	7/22, [client A] noticed the			monitor and address any issue	es in	
	overnight staff DSP	(Direct Support Professional)			the home at least once weekly	,	
	[Staff #9] was not in	nside the home or on the			during Site Supervisory visits		
		called [staff #6] to report the					
		ram director) #1] was informed					
	of the incident on 1	1/17/22 at 12:02pm. Plan to			Persons Responsible: Area		
	Resolve: [Staff #9]	was immediately suspended			Director, Program Director,		
		e of this investigation. This			Program Supervisor, Regiona	ı	
	-	nitiated on 11/17/22, and it will			Director		
	-	mely manner." This affected					
	clients A, B, C, D, l	E, F, G and H.					
		Follow Up dated 11/18/22					
		interviewed [Staff #9] on					
		^{‡9}] stated she did not leave the					
	-	ift. [Staff #9] stated she went					
		round 11pm) to smoke, but it					
		ne quickly returned inside the					
		ated the only resident she saw					
	-	[client B] when she made him					
		n 1-2 am. [Staff #9] stated she					
	did not see another	resident during her shift.					
	O 11/10/02 FBB #5	13 1 14 5 4 60 1163 50 400					
	_	l] spoke with [staff #6]. [Staff					
		called him around 1 AM on					
		stated [client A] told him [staff					
	_	nd returned 20 to 30 minutes ed [client A] reported [Staff #9]					
		ed [Client A] reported [Staff #9] na. [Client #6] reportedly told					
	[client A] he would						
	Lenent Will he would	nanuic it.					
	On 11/18/22 [DD #	1] interviewed [client A] via					
	_	A] stated he saw [staff #9]					
		pproximately midnight. [Client					
		ed about 30 minutes later.					
	A] stated she return	eu about 30 mmutes fater.					

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PRINTED: 05/04/2023

	Γ OF HEALTH AND HU R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	` ′	JILDING	INSTRUCTION 00	(X3) DATE	SURVEY
	PROVIDER OR SUPPLIER			110 W F	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151		
TRANSIT (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF [Client A] reported when [staff #9] left [Client A] stated th she left. [Client A] awake at that time. one other time 'a lo mention [staff #9] s On 11/18/22, [PD # telephone. [Client H window when he sa stated he saw her in know where she we he is 'pretty sure' th she left, [client B] w gone or when she re knowledge of this b 11/17/22. Describe systemic a health and safety is evidence to support left the home during #1] discussed with property during her inappropriate and c action. [Staff #9] st did not leave the pr	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION he was looking out his window and went across the street. e door alarm did go off when stated [client B] was also [Client A] stated this happened ing time ago.' [Client A] did not smelling of marijuana. [41] interviewed [client B] via [43] stated he was looking out his aw [Staff #9] leave. [Client B] at the street, but he did not ent from there. [Client B] stated e door alarms went off when was not sure how long she was eturned. [Client B] had no behavior happening prior to [45] actions being taken to assume sues: There is a lack of actions ac				E	(X5) COMPLETION DATE
	failed to thoroughly made by client A. T	eports indicated the facility investigate the allegation. The facility failed to address the 1#9 smelled like marijuana.					

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The Area Director (AD) was interviewed on 3/7/23 at 10:00 AM. The AD stated the investigation was conducted by a previous program director. The AD indicated the allegation was not thoroughly

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G300	B. W	ING		03/13/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER				PIKE ST		
TRANSIT	TIONAL SERVICES	SUBLIC			NSVILLE, IN 46151		
TO WHO THOU WE DELIVED BY SOME LED							
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	D stated "the suspicion of use					
policy should have been followed" regarding the							
	allegation the staff s	smelled like marijuana.					
	T 0 1'C 11 4 11	(1D: 1337 D C : 1					
		ectual Disabilities Professional					
		rector (PD) was interviewed on . The QIDP/PD indicated he is					
		tions. The QIDP/PD indicated					
	_	is not thorough. The QIDP/PD					
	_	of drug use by a client would					
	warrant drug testing						
	warrant arag testing	, for the starr.					
	2. The facility's Bur	reau of Developmental					
		s (BDDS) reports were					
		3 at 12:30 PM. The review					
	indicated the follow						
		8					
	A BDDS report date	ed 12/22/22 at 8:30 am					
	_	2/2022 about 6:30 AM [client					
	A] started demandir	ng that staff take him to the					
	bank to cash his \$22	2 check that had arrived in the					
	mail earlier in the w	veek. Staff informed [client A]					
	that the bank didn't	open until about 8:30 AM and					
	that they would take	e him to the bank between 8:30					
	and 9:00 AM. Abou	at 8:30 AM [client A] started					
	-	f take him to the bank. Staff					
	-	I take him as soon as they					
		ey were working on. [Client A]					
		staff and said f you, I need					
		without you then by my d					
		exited the house. Staff					
		d the keys to the van and					
		ient A] . While following					
		atedly prompted him to get in					
		old temperature and said that					
		m to the bank. [Client A]					
		van and continued walking in					
		bank. Once at the bank [client drive thru window and					
	-	fter cashing his check [client					
	cashed his check. A	ner cashing his check [chefit					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED				
		15G300	B. W	/ING	_	03/13	/2023
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8	110 W PIKE ST				
TRANSIT	IONAL SERVICES	SUB LLC			NSVILLE, IN 46151		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	OF CORRECTION (
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		get in the van with staff and					
		ne gas station to buy himself					
		after walking out of the gas					
		gain refused to get in the van					
		ed all the way home. [Client A] house roughly 9:37 AM. While					
		exhibited good pedestrian					
		t A] was within line of sight of					
	-	that he was away from the					
		at [client A] uses is 2 blocks					
		the gas station that he went to					
		from away from his home.					
		ner incidents for the remainder					
	of the day. Staff wil	ll continue to follow [client A's]					
	BSP (Behavior Sup	port Plan) and encourage him					
	to use his coping sk	tills when he is upset."					
	A RDDS report date	ed 2/10/23 at 12:30 PM					
	_	0/2023 [client A] left the group					
		om and walked to the bank 2					
	-	at staff supervision. While at					
	the bank [client A]	-					
		B's] bank account using his					
	-	cation card. When unable to					
		[client A] returned home.					
	[Client A] has a BS	P (Behavior Support Plan) that					
		orthy behavior and elopement.					
	Plan to Resolve: Sta	aff will continue to follow					
	[client A's] BSP and	d an investigation has been					
	initiated."						
	An investigation da	ted 2/22/23 indicated, "[Client					
	_	on 2/21/23. [Client A] stated					
	-	the house during the					
	-	3. [Client A] stated that he					
		entification card and went to the					
	-	to withdraw money. [Client A]					
	_	ot take his check and attempt					
	to cash it. [Client A] stated that his staff [staff #4]					
	and [staff #5] were	working on 2/10/23. [Client A]					
	i		1	I			Ī

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/13/2023
	ROVIDER OR SUPPLIER		110 W I	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION Toff that he was going outside	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	to vape and went to that [staff #5] was it in the living room. It is less than two blocestimated that he was [Staff #5] was interstated that she was some Group Home on 2/1 heard the door alarmstated that she open A] vaping on the from that she went back to [Staff #5] stated that cleaning and assisting room. [Staff #5] stated that cleaning and assisting to cash a identification. When she stated that [client A] denies that [client A] denies that [client A] denies that [client A] denies that the was in A] went out the door #5] checked on him [Staff #4] stated that home. [Staff #4] stated that home after [Staff #4] stated that the bank called and	aff that he was going outside the bank. [Client A] stated in the office and [staff #4] was [Client A] stated that the bank eks from the home. [Client A] as gone for only ten minutes. Viewed on 2/21/23. [Staff #5] working in the Martinsville 0/23. [Staff #5] stated that she in by the front door. [Staff #5] ed the door and saw [client ont porch. [Staff #5] stated to the office to complete work. It other staff [staff #4] was ing other clients in the living ted that she received a phone elaiming that [client A] was in check and had [client B's] in [staff #5] got off the phone, int A] had walked in the door the kitchen. [Staff #5] stated and leaving the home. [Staff #5] I denied having [client B's] viewed on 2/21/23. [Staff #4] in the living room when [client or. [Staff #4] stated that [staff and went back into the office. It he continued cleaning the ted that he saw [client A] walk approximately ten minutes. It [staff #5] informed him that stated [client A] was there. It [client A] denied having ation card.			
		viewed on 2/22/23. [Staff #6] notified him of [client A's]			

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	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 03/13/2023		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 110 W PIKE ST MARTINSVILLE, IN 46151				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)			
	representative from [client A] attempted [client A] dentification at first attempt to withdraw [client A] returned not return the check A] gets the mail at the check then. [Staff # to call Social Securian new one issued for [Client B] was interestated that he was now his identification can be stated that he wis keeping. [Client B] with [client A] and him. Conclusion: It is sure [client B's] identification can attempted to can substantiated that [conclusions: A's] BSP for eloper [client A] outside with [client B] about and will assist in serequest a new Social and will reimburse Staff will observe in ensure any individue Completed by: [Regions of the client B] [completed by: [Regions of the completed by: [Regions of the client B] about and will reimburse Staff will observe in ensure any individue Completed by: [Regions of the client B] [R	viewed on 2/21/23. [Client B] ot aware of [client A] taking rd until it was returned. [Client II keep it in his wallet for safe stated that he was not angry enjoys living in the home with bestantiated that [client A] took ration and Social Security check sh it at the bank, it is also client A] eloped from the home					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/13/2023
	PROVIDER OR SUPPLIEF		110 W	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
	address staff neglecthat client A eloped	t due to staff not being aware from the home. The review adations made by the			
	at 10:00 AM. The A conducted by a prev AD indicated the al investigated. The A should first look int neglectful in caring indicated recommendations finot implemented. Trecommendations finot implemented yed that this week." The Qualified Intell (QIDP)/Program Di 3/7/23 at 10:00 AM investigations traincinvestigation was neglected.	AD) was interviewed on 3/7/23 AD stated the investigation was vious program director. The legation was not thoroughly D stated "investigations to whether or not staff were for the clients." The AD indations should be developed the AD stated the rom client A's elopements were straightful because "we were going to because "we were going to because "we were going to be at the QIDP/PD indicated he is ed. The QIDP/PD indicated the ot thorough. The QIDP/PD attions should be addressed as			
	again." 3. The facility's But	reau of Developmental s (BDDS) reports were			
		3 at 12:30 PM. The review			
	indicated, "On 02/0 eating his lunch he he was still hungry. and [client B] began and peers. [Client E over the ash tray on	ed 2/5/23 at 12:35 PM 5/2023 after [client B] finished became upset and stated that Staff offered him more food a yelling and cussing at staff B] also slammed doors, knocked the porch and informed staff he was going to leave the			

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300		UILDING	nstruction <u>00</u>	(X3) DATE COMPL 03/13/	ETED
	PROVIDER OR SUPPLIER		•	110 W F	DDRESS, CITY, STATE, ZIP COD PIKE ST ISVILLE, IN 46151	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	home. Staff informed property that they were the staff were the or moment. About 12: property walking in station that he enjoy that time staff called local police departing [client B] at the near with [client B] and and then drove him incidents for the rere had a change to his minute alone time of where local law enforced [client B] leaves the B] has good pedestroisk when walking in Plan to Resolve: Staff [client B's] BSP." A BDDS report date indicated, "On 02/1 woke up from a napunknown reasons. A went upstairs to [client B] the house. Staff is a sistance to locate to there being one so returned [client B] to the plan to Resolve: Staff is a bound of the plan to Resolve: Staff is a bound of the plan to Resolve: Staff is a bound of the plan to Resolve: Staff is BSP to allow alone.	ed [client B] that if he left the yould have to call the police as ally staff at the house at the 35 PM [client B] left the 4 the direction of a nearby gas as going to to get drinks. At d management and then call the ment for assistance. Police met arby gas station. Police spoke bought him a fountain drink home. There were no further mainder of the day. [Client B] BSP that removed his 30 due to misuse and put in place forcement to be notified when a home unsupervised. [Client trian safety skills and is not at in the community. Aff will continue to follow [About 8:20 pm [client B] then sent A's] room and stole \$1 d then went back down stairs [Staff called [city] police for [client B] after he eloped due taff on shift at the time. Police to the house about 8:50 pm. P that addresses aggression tructive to property, a socially offensive behavior, vior, elopement, and or. aff met on 02/20/2023 to revise time and is currently awaiting An investigation is being					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			ETED
		15G300	B. W	NG		03/13/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	L			PIKE ST		
TRANSIT	IONAL SERVICES	SUBILC			NSVILLE, IN 46151		
,			1	<u> </u>			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	4 BBBG 1 .	10/00/02 0 20 73 5					
	_	ed 2/20/23 at 8:30 PM					
		/23 about 8:30 PM [client B]					
		unknown reasons and left the ed [client B] in a vehicle to a					
		house. [Client B] forced his					
	_	pushing the gas station					
		way. Police were called and					
		to speak with [client B]. Once					
		he got in staffs (sic) vehicle					
		I home. [Client B] has a BSP					
	_	ession towards others,					
		property, disruptive behavior,					
	` ´ *	ehavior, uncooperative					
	-	t, and hyperactive behavior.					
	Plan to resolve: Stat	ff will continue to follow [client					
	B's] BSP and intera-	ctions between individuals for					
	health and safety."						
	_	ted 2/27/23 indicated, "[Client					
	_	on 2/21/23. [Client B] stated					
	_	et because [client A] received					
	•	nd he wanted one. [Client B]					
		d to the gas station and staff					
		d to have him come back to the					
		nt B] stated that [Staff #10] met					
	_	on. [Client B] stated that [staff					
	-	ot enter the gas station and					
		er. [Client B] stated that the gas					
		d him not to enter and to listen B] stated that he ignored them					
	_	station. [Client B] stated that					
	_	gas station staff nor make any					
		n. [Client B] stated that he got					
		gas station and paid for it.					
		at he refused to ride home with					
		king back to the group home.					
		at the police stopped him and					
		not leaving the group home					
	_	[Client B] stated that he					
	1						

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	of correction (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER (15G300)	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 03/13/2023
	PROVIDER OR SUPPLIER TIONAL SERVICES SUB LLC	110 W I	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	returned back to the group home after speaking with the police.			
	[Staff #5] was interviewed on 2/22/23. [Staff #5] stated that she was driving the van on an outing with the other individuals in the home. [Staff #5] stated that she noticed staff [staff #10] at the gas station and watched [Client B] go inside. [Staff #5] stated that she did not witness [Client B] force himself into the gas station. [Staff #5] stated that when [Client B] left the gas station, he refused a ride home. [Staff #5] stated that she witnessed [client B] speaking with the police and they spoke to him about not leaving the group home without permission. [Staff #5] stated that [Client B] was cooperative and return to the group home without further incident. [Staff #6] Program Supervisor, was interviewed on 2/23/23. [Staff #6] stated that he received a report from DSP [staff #11] that [client B] eloped from the group home and [staff #10] was attempting to convince [client B] to return to the home. [Staff #6] stated that [staff #11] reported that [client B]			
	was refusing to return to the home and went into the gas station after being told not to. [Staff #6] stated that it was reported that the police were called and spoke to [client B] while he was walking home. [Staff #6] stated that no further incidents were reported to him that night involving [Client B]. [Staff #11] DSP, was interviewed on 2/27/23. [Staff #11] stated that he was working in the home on the night of 2/20/23. [Staff #11] stated that he witnessed [client B] leave the home and [Staff #10], DSP, followed him. [Staff #11] stated that he stayed at the home with remaining individuals present. [Staff #11] stated that he reported the incident to [Staff #6], Program Supervisor. [Staff			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G300	B. W	ING		03/13/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER				PIKE ST		
TRANSIT	IONAL SERVICES	SUBLIC			NSVILLE, IN 46151		
				1,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	101122, 111 10101		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	f told him that [Client B] was					
		the gas station without					
	-	11] stated that staff told him					
		ed a ride home and the police					
	_	#11] stated that [Client B] did					
	not have any further	r incidents that evening.					
	[Stoff#10] DCD	as interviewed on 2/27/23.					
		as interviewed on 2/2//23. at [client B] became upset and					
		ne on 2/20/23. [Staff #10]					
		npted to get [client B] to come					
		Staff #10] stated that when					
	_	she met him at the gas station.					
		at the gas station attendant					
		[client B] was on his way.					
		at she told the gas station					
		tempt to get [client B] home as					
		at permission. [Staff #10]					
		B] arrived the gas station staff					
	_	r and to go home with staff.					
		at [client B] ignored them and					
		on and bought a drink. [Staff					
	-	gas station staff asked her to					
	call the police in wh	nich she did so. [Staff #10]					
	stated that [client B]] may have made slight					
	contact with the gas	station					
	staff but it was unin	tentional. [Staff #10] stated					
		ed to be transported home.					
		at [staff #5], DSP, arrived in					
		[client B] ignored her as well.					
		at while [client B] was walking					
	-	rs stopped him and spoke with					
		ng the home without					
		10] stated that [Client B]					
	returned home with	out further incident.					
		bstantiated that [client B]					
	-	ne, it is unsubstantiated that					
	[client B] shoved th	e gas station staff.					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/13/2023
	ROVIDER OR SUPPLIER		110 W I	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION GEACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	OBE COMPLETION
1100	Recommendations: updated BSP that ir [client B], staff will	Staff will be trained on acludes alone time each day for be trained on incident ion. Competed by [Regional	140		DATE
	for the 2/5/23 and 2 and theft of client A indicated the invest followed client B's	d there were no investigations /19/23 incidents of elopement ts money. The review igation did not address if staff BSP to address his behavior of up to the elopement.			
	at 10:00 AM. The A investigation for cli and 2/19/23. The A (investigation) for t stated the investigat Regional Director f The AD indicated throughly investig "incidents of eloper	AD) was interviewed on 3/7/23 AD indicated there was no ent B's elopements on 2/5/23 D stated, "I don't have one hose incidents." The AD tion was conducted "by the or [client B's] last elopement." the allegation was not ated. The AD stated ment should address whether SP was followed by staff."			
	(QIDP)/Program Di 3/7/23 at 10:00 AM investigation should not staff neglected to	ectual Disabilities Professional frector (PD) was interviewed on a The QIDP/PD indicated the have addressed whether or to follow client B's BSP. The tere were some items left out of			
	Risk Management previewed. The police Mentor promotes a seeks to protect ind Mentor services thr	M, the facility's Quality and policy, dated April 2011, was by indicated, in part, "Indiana high quality of service and ividuals receiving Indiana ough oversight of dures and company operations,			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED		
		15G300	B. WING		03/13/2023
	PROVIDER OR SUPPLIER		110 V	T ADDRESS, CITY, STATE, ZIP COD V PIKE ST FINSVILLE, IN 46151	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	process of identifying risk to which individently 2011 Human Rights following actions and Indiana MENTOR:	service delivery and through a ng evaluating and reducing duals are exposed" The April spolicy indicated, in part, "The re prohibited by employees of abuse, neglect, exploitation or individual including misuse of s; or violation of an			
W 0154	483.420(d)(3) STAFF TREATME	ENT OF CLIENTS			
Bldg. 00	The facility must halleged violations Based on record revallegations of abuse unknown origin reverse, G and H, the faciallegation of staff nonecondering investigated, and facincidents of elopem. Findings include: The facility's Bureas Services (BDDS) reat 12:30 PM. The result in the facility is Bureas Services (BDDS) reported indicated, "On 11/1 overnight staff DSP [Staff #9] was not in property, [client A] incident. [PD (prografice of the incident on 1 Resolve: [Staff #9] pending the outcomes	ave evidence that all are thoroughly investigated. Fiew and interview for 6 of 6 or neglect and injuries of iewed for clients A, B, C, D, E, lity failed to ensure an eglect was thoroughly illed to thoroughly investigate ent for clients A and B. The original of the following: The original of the control	W 0154	- Program Director and Director will be trained on increporting and investigations was pecific outcome of investigations of the program Director will meet with Program Directors at least weekly to discuss all incident and investigations All staff will be trained incident reporting All staff will be trained Abuse and Neglect and Client Rights Program Supervisor was monitor and address any issueduring home visits at least the times per week Program Director will monitor and address any issue the home at least once week during Site Supervisory visits Area Director will moniat least once weekly during Supervisory Visits.	ident vith a tions t st st s on on t vill ues ree

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G300		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 03/13/2023	
	ROVIDER OR SUPPLIEF		110 W	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF be completed in a ti	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION mely manner." This affected	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	clients A, B, C, D, 1 A BDDS Incident Findicated, "[PD #1] 11/17/2022. [Staff #home during her shoutside one time (arwas too cold, and shome. [Staff #9] stafter midnight was cheese fries betwee did not see another On 11/18/22 [PD # #6] stated [client A] 11/17/22. [Staff #6] #9] left the home ar later. [Staff #6] stat smelled of marijuar [client A] he would On 11/18/22, [PD # telephone. [Client A] leave the home at a A] stated she return [Client A] reported when [staff #9] left [Client A] stated the she left. [Client A] awake at that time. one other time 'a low mention [staff #9] stated he saw her in know where she we stated he saw her in know where she we	Collow Up dated 11/18/22 interviewed [Staff #9] on #9] stated she did not leave the iff. [Staff #9] stated she went round 11pm) to smoke, but it ne quickly returned inside the ited the only resident she saw [client B] when she made him in 1-2 am. [Staff #9] stated she resident during her shift. 1] spoke with [staff #6]. [Staff called him around 1 AM on stated [client A] told him [staff ind returned 20 to 30 minutes and [client #6] reported [Staff #9] and [Client #6] reportedly told		Persons Responsible: Area Director, Program Supervisor, Regions Director	al
	she left, [client B] v	vas not sure how long she was			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COMI	E SURVEY PLETED 3/2023
	PROVIDER OR SUPPLIEF		110 W	ADDRESS, CITY, STATE, ZIP CO PIKE ST NSVILLE, IN 46151	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION eturned. [Client B] had no	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	11/17/22.	behavior happening prior to actions being taken to assume				
	health and safety is evidence to support left the home during	sues: There is a lack of the allegation that [staff #9] g her shift. On 11/17/22, [PD [staff #9] that leaving the				
	property during her inappropriate and c action. [Staff #9] st	shift was absolutely ould result in disciplinary ated she understood, and she operty on 11/17/22.				
	Due to lack of evid	ence, [Staff #9] should be				
	failed to thoroughly made by client A. T	investigate the allegation The facility failed to address the #9 smelled like marijuana.				
	at 10:00 AM. The A conducted by a pred AD indicated the al	(AD) was interviewed on 3/7/23 AD stated the investigation was vious program director. The legation was not thoroughly				
	policy should have allegation the staff	D stated "the suspicion of use been followed" regarding the smelled like marijuana.				
	(QIDP)/Program D 3/7/23 at 10:00 AM trained on investigation was	lectual Disabilities Professional irector (PD) was interviewed on I. The QIDP/PD indicated he is utions. The QIDP/PD indicated as not thorough. The QIDP/PD in of drug use by a client would g for the staff."				
	indicated, "On 12/2	dated 12/22/22 at 8:30 am 2/2022 about 6:30 AM [client ng that staff take him to the				

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

PRINTED: 05/04/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING	(X3) DATE SURVEY COMPLETED		
		15G300	B. WING		03/13/2023
	PROVIDER OR SUPPLIE		110 W	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
TAG	bank to cash his \$2 mail earlier in the withat the bank didn't that they would take and 9:00 AM. About demanding that states as a said that they would finished the task the began screaming at my chew, I'm going self. [Client A] the immediately grabbe began following [cast] A] staff repeatedly due to the cold term would drive him to get in the van and direction of the bar walked up to the direction of the bar walked up to the direction of the di	22 check that had arrived in the week. Staff informed [client A] to open until about 8:30 AM and the him to the bank between 8:30 ut 8:30 AM [client A] started ff take him to the bank. Staff d take him as soon as they ey were working on. [Client A] to staff and said f you, I need g without you then by my d n exited the house. Staff ed the keys to the van and lient A]. While following [client prompted him to get in the van uperature and said that they the bank. [Client A] refused to continued walking in the alk. Once at the bank [client A] rive thru window and cashed shing his check [client A] still e van with staff and instead	IAU		DAIL
	tobacco. After wall [client A] again ref and walked all the back at the house r walking [client A] safety skills. [Clier staff the entire time house. The bank th from his home and is roughly 9 blocks There were no furt of the day. Staff with BSP (Behavior Superior Language 1) and BDDS report indicated, "On 02/1	tation to buy himself chewing king out of the gas station fused to get in the van with staff way home. [Client A] arrived oughly 9:37 AM. While exhibited good pedestrian at A] was within line of sight of that he was away from the at [client A] uses is 2 blocks the gas station that he went to a from away from his home. The incidents for the remainder all continue to follow [client A's] poport Plan) and encourage him kills when he is upset." dated 2/10/23 at 12:30 PM 10/2023 [client A] left the group pum and walked to the bank 2			

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05/04/2023 PRINTED: FORM APPROVED OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 15G300 03/13/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 110 W PIKE ST TRANSITIONAL SERVICES SUB LLC MARTINSVILLE, IN 46151 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE blocks away without staff supervision. While at the bank [client A] attempted to access housemate [client B's] bank account using his [client B's] identification card. When unable to access the account [client A] returned home. [Client A] has a BSP (Behavior Support Plan) that addresses untrustworthy behavior and elopement. Plan to Resolve: Staff will continue to follow [client A's] BSP and an investigation has been initiated."

An investigation dated 2/22/23 indicated, "[Client A] was interviewed on 2/21/23. [Client A] stated that he eloped from the house during the afternoon on 2/10/23. [Client A] stated that he took [client B's] identification card and went to the bank and attempted to withdraw money. [Client A] stated that he did not take his check and attempt to cash it. [Client A] stated that his staff [staff #4] and [staff #5] were working on 2/10/23. [Client A] stated that he told staff that he was going outside to vape and went to the bank. [Client A] stated that [staff #5] was in the office and [staff #4] was in the living room. [Client A] stated that the bank is less than two blocks from the home. [Client A] estimated that he was gone for only ten minutes.

[Staff #5] was interviewed on 2/21/23. [Staff #5] stated that she was working in the Martinsville Group Home on 2/10/23. [Staff #5] stated that she heard the door alarm by the front door. [Staff #5] stated that she opened the door and saw [client A] vaping on the front porch. [Staff #5] stated that she went back to the office to complete work. [Staff #5] stated that other staff [staff #4] was cleaning and assisting other clients in the living room. [Staff #5] stated that she received a phone call from the bank claiming that [client A] was attempting to cash a check and had [client B's] identification. When [staff #5] got off the phone,

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	of correction (X1) provider/supplier/clia (IDENTIFICATION NUMBER (15G300)	(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 03/13/2023
	PROVIDER OR SUPPLIER FIONAL SERVICES SUB LLC	110 W I	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	she stated that [client A] had walked in the door and was standing in the kitchen. [Staff #5] stated that [client A] denied leaving the home. [Staff #5] stated that [client A] denied having [client B's] identification card.			
	[Staff #4] was interviewed on 2/21/23. [Staff #4] stated that he was in the living room when [client A] went out the door. [Staff #4] stated that [staff #5] checked on him and went back into the office. [Staff #4] stated that he continued cleaning the home. [Staff #4] stated that he saw [client A] walk into the home after approximately ten minutes. [Staff #4] stated that [staff #5] informed him that the bank called and stated [client A] was there. [Staff #4] stated that [client A] denied having [client B's] identification card.			
	[Staff #6] was interviewed on 2/22/23. [Staff #6] stated that [staff #5] notified him of [client A's] elopement. [Staff #6] stated that he spoke with a representative from the bank and they stated that [client A] attempted to cash [client B's] check with [client B's] identification card. [Staff #6] stated that [client A] denied having [client B's] identification at first but admitted to using it to attempt to withdraw money. [Staff #6] stated that [client A] returned the identification card but did not return the check. [Staff #6] stated that [client A] gets the mail at times and believes he took the check then. [Staff #6] stated that he is attempting to call Social Security to cancel the check and get a new one issued for [client B].			
	[Client B] was interviewed on 2/21/23. [Client B] stated that he was not aware of [client A] taking his identification card until it was returned. [Client B] stated that he will keep it in his wallet for safe keeping. [Client B] stated that he was not angry with [client A] and enjoys living in the home with			

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i '		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED				
		15G300	B. WING			03/13/2023	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 110 W PIKE ST MARTINSVILLE, IN 46151				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S BLANCE CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	him.						
	Conclusion: It is sul [client B's] identific and attempted to casubstantiated that [client approximately to a substantiated that [client A] outside with [client B] about and will assist in serequest a new Social and will reimburse is Staff will observe in ensure any individu Completed by: [Regard The review of record address staff neglecthat client A eloped indicated recommer investigator were not the Area Director (at 10:00 AM. The Aconducted by a prevadout AD indicated the all investigated. The A should first look into neglectful in caring indicated recommer and implemented. Trecommendations for the approximate the substantial and implemented. Trecommendations for the aconducted to the should first look into neglectful in caring indicated recommendations for the aconducted the substantial and implemented. Trecommendations for the aconducted the substantial and implemented. Trecommendations for the aconducted the substantial and implemented. Trecommendations for the aconducted the substantial and the substanti	All staff retrained on [client ment and stealing. Staff will join when he vapes. Team will meet at securing his identification curing if requested. Team will all Security check for [client B] if he is not able to obtain it. Individuals getting the mail to all checks are received. It is individuals getting the mail to all checks are received. It is individual bit in the properties of the					
		ectual Disabilities Professional rector (PD) was interviewed on					

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

PRINTED: 05/04/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G300		r í	UILDING	instruction 00	(X3) DATE (COMPL 03/13/	ETED	
	ROVIDER OR SUPPLIEF			110 W F	NDDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY)		TE	(X5) COMPLETION DATE
	investigations traindinvestigation was no stated "recommend soon as possible so again." 4. A BDDS report of indicated, "On 02/0 eating his lunch he he was still hungry, and [client B] begand peers. [Client B] over the ash tray on multiple times that home. Staff information property that they were the staff were the or moment. About 12: property walking in station that he enjoy that time staff called local police department [client B] at the near with [client B] and and then drove him incidents for the remained a change to his minute alone time of where local law entition [client B] leaves the B] has good pedestream.	I. The QIDP/PD indicated he is ed. The QIDP/PD indicated the of thorough. The QIDP/PD ations should be addressed as the action doesn't occur Idated 2/5/23 at 12:35 PM 5/2023 after [client B] finished became upset and stated that Staff offered him more food in yelling and cussing at staff B] also slammed doors, knocked in the porch and informed staff he was going to leave the ed [client B] that if he left the would have to call the police as inly staff at the house at the 35 PM [client B] left the inthe direction of a nearby gas way going to to get drinks. At indicate the ment for assistance. Police met in the gas station. Police spoke bought him a fountain drink home. There were no further mainder of the day. [Client B] BSP that removed his 30 due to misuse and put in place forcement to be notified when the home unsupervised. [Client rian safety skills and is not at					
	Resolve: Staff will BSP."	in the community. Plan to continue to follow [client B's]					
	indicated, "On 02/1 woke up from a nap	dated 2/19/23 at 8:20 PM 9/2023 about 8:00 pm [client B] o and became agitated for About 8:20 pm [client B] then					

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

PRINTED: 05/04/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G300		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/13/2023	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD PIKE ST	-
TRANSIT	TONAL SERVICES	SUB LLC	MARTII	NSVILLE, IN 46151	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LISC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
	-	ent A's] room and stole \$1			
		d then went back down stairs			
		Staff called [city] police for			
		[client B] after he eloped due taff on shift at the time. Police			
	_	to the house about 8:50 pm.			
		P that addresses aggression			
	towards others, desi				
	disruptive behavior	, socially offensive behavior,			
	_	vior, elopement, and			
		or. Plan to Resolve: Staff met			
		vise BSP to allow alone time			
	and is currently awaiting guardian approval. An investigation is being initiated on the missing				
	money."	ig initiated on the imissing			
	,				
	6. A BDDS report of	lated 2/20/23 at 8:30 PM			
	indicated, "On 2/20	/23 about 8:30 PM [client B]			
	_	unknown reasons and left the			
		ed [client B] in a vehicle to a			
	-	house. [Client B] forced his			
	-	pushing the gas station way. Police were called and			
		to speak with [client B]. Once			
		he got in staffs (sic) vehicle			
		I home. [Client B] has a BSP			
	_	ession towards others,			
		property, disruptive behavior,			
	-	ehavior, uncooperative			
	behavior, elopement, and hyperactive behavior. Plan to resolve: Staff will continue to follow [client				
		_			
	B's] BSP and interactions between individuals for health and safety."				
	mountaina saicty.				
	An investigation da	ted 2/27/23 indicated, "[Client			
	_	on 2/21/23. [Client B] stated			
	_	et because [client A] received			
		nd he wanted one. [Client B]			
		ed to the gas station and staff			
	[staff #10] attempte	d to have him come back to the			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 15G300 03/13/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 110 W PIKE ST MARTINSVILLE, IN 46151 TRANSITIONAL SERVICES SUB LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Group Home. [Client B] stated that [Staff #10] met him at the gas station. [Client B] stated that [staff #10] asked him to not enter the gas station and return home with her. [Client B] stated that the gas station worker asked him not to enter and to listen to his staff. [Client B] stated that he ignored them and went in the gas station. [Client B] stated that he did not push the gas station staff nor make any threats towards them. [Client B] stated that he got a drink while in the gas station and paid for it. [Client B] stated that he refused to ride home with staff and began walking back to the group home. [Client B] stated that the police stopped him and spoke to him about not leaving the group home without permission. [Client B] stated that he returned back to the group home after speaking with the police. [Staff #5] was interviewed on 2/22/23. [Staff #5] stated that she was driving the van on an outing with the other individuals in the home. [Staff #5] stated that she noticed staff [staff #10] at the gas station and watched [Client B] go inside. [Staff #5] stated that she did not witness [Client B] force himself into the gas station. [Staff #5] stated that when [Client B] left the gas station, he refused a ride home. [Staff #5] stated that she witnessed [client B] speaking with the police and they spoke to him about not leaving the group home without permission. [Staff #5] stated that [Client B] was cooperative and return to the group home without further incident. [Staff #6] Program Supervisor, was interviewed on 2/23/23. [Staff #6] stated that he received a report from DSP [staff #11] that [client B] eloped from the group home and [staff #10] was attempting to convince [client B] to return to the home. [Staff #6] stated that [staff #11] reported that [client B] was refusing to return to the home and went into

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G300		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/13/2023				
	PROVIDER OR SUPPLIEF		110 W	STREET ADDRESS, CITY, STATE, ZIP COD 110 W PIKE ST MARTINSVILLE, IN 46151				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP	BE COMPLETION			
PREFIX TAG	the gas station after stated that it was recalled and spoke to walking home. [Statincidents were repoinvolving [Client B] [Staff #11] DSP, wa #11] stated that he with enight of 2/20/23 witnessed [client B] #10], DSP, followerstayed at the home present. [Staff #11] incident to [Staff #6] #11] stated that staff defiant and entered permission. [Staff #6] that [client B] refus were called. [Staff #10], DSP, was [Staff #10] stated the stated that she attendated that she will attend the was there without stated when [client told him not to enter [Staff #10] stated the was there without stated that she will attend the was there without stated when [client told him not to enter [Staff #10] stated the staff #10] stated the was there without stated when [client told him not to enter [Staff #10] stated the staff #10] stated the was there without stated when [client told him not to enter [Staff #10] stated the staff #10] stated the staff #10] stated the was there without stated when [client told him not to enter [Staff #10] stated the staff #10] stated the staff #10] stated the was there without stated when [client told him not to enter [Staff #10] stated the staff #10] stated the was the was the will was the was	being told not to. [Staff #6] ported that the police were [client B] while he was ff #6] stated that no further rted to him that night]. as interviewed on 2/27/23. [Staff was working in the home on . [Staff #11] stated that he leave the home and [Staff d him. [Staff #11] stated that he with remaining individuals stated that he reported the following, Program Supervisor. [Staff ff told him that [Client B] was the gas station without full stated that staff told him ed a ride home and the police full stated that [Client B] did r incidents that evening. as interviewed on 2/27/23. that [client B] became upset and the on 2/20/23. [Staff #10] the policy of the policy of the policy of the policy of the policy staff #10] stated that when she met him at the gas station. The policy of the policy	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD I	BE COMPLETION			
	#10] stated that the call the police in wh	on and bought a drink. [Staff gas station staff asked her to nich she did so. [Staff #10]] may have made slight						

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î î		r '	CONSTRUCTION 00	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING	COMPLETED		
15G300		B. WING		03/13/2023	
	PROVIDER OR SUPPLIER		110 \	ET ADDRESS, CITY, STATE, ZIP COD W PIKE ST TINSVILLE, IN 46151	•
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DROWIDERIC BLAN OF CORRECT	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL)	OBE COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPRODEFICIENCY)	DATE
	contact with the gas	s station			
		ntentional. [Staff #10] stated			
		ed to be transported home.			
	-	nat [staff #5], DSP, arrived in			
		[client B] ignored her as well.			
	-	nat while [client B] was walking			
	_	rs stopped him and spoke with			
		ng the home without			
		10] stated that [Client B]			
	returned home with	out further incident.			
	Conclusion: It is sul	bstantiated that [client B]			
		ne, it is unsubstantiated that			
	[client B] shoved th				
	Recommendations:	Staff will be trained on			
	updated BSP that in	ncludes alone time each day for			
	[client B], staff will	be trained on incident			
	reporting investigat	ion. Competed by [Regional			
	Director] 2/27/23."				
	for the 2/5/23 and 2 elopement and his t review indicated the if staff followed clie	ed there was no investigation 1/19/23 incidents of client B's heft of client A's money. The e investigation did not address ent B's BSP to address his n which led up to the			
	at 10:00 AM. The A investigation for cli and 2/19/23. The A (investigation) for t stated the investigat Regional Director f The AD indicated thoroughly investig "incidents of eloper	(AD) was interviewed on 3/7/23 AD indicated there was no ent B's elopements on 2/5/23 D stated, "I don't have one hose incidents." The AD tion was conducted "by the for [client B's] last elopement." the allegation was not ated. The AD stated ment should address whether SP was followed by staff."			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING <u>00</u> COMPLETE			LETED	
		15G300	B. WI	NG		03/13/	/2023
)	NOT THE OF STATE			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	t			PIKE ST		
TRANSIT	TIONAL SERVICES	SUB LLC	_	MARTII	NSVILLE, IN 46151		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	(QIDP)/Program Di 3/7/23 at 10:00 AM investigation should not staff neglected t	lectual Disabilities Professional irector (PD) was interviewed on I. The QIDP/PD indicated the I have addressed whether or to follow client B's BSP. The here were some items left out of					
W 0157	483.420(d)(4)						
D	STAFF TREATME						
Bldg. 00		tion is verified, appropriate					
	corrective action r	and record review for 2 of 3	$ \mathbf{w} $	157	- Program Director and A	Δrea	04/28/2023
		ents A and B), the facility	I w c	13/	Director will be trained on incident		04/28/2023
		rective measures were			reporting and investigations w		
		emented to address incidents			specific outcome of investigations w		
	of elopement for cli				- Program Directors and		
	Findings include:				Area Director will be trained identifying conclusions for the		
	1. The facility's Bur	reau of Developmental			investigations and ensuring all recommendations are comple		
	1	s (BDDS) reports were			- Area Director will meet		
		3 at 12:30 PM. The review			with Program Directors at leas		
	indicated the following: A BDDS report dated 12/22/22 at 8:30 am indicated, "On 12/22/2022 about 6:30 AM [client A] started demanding that staff take him to the bank to cash his \$22 check that had arrived in the mail earlier in the week. Staff informed [client A] that the bank didn't open until about 8:30 AM and that they would take him to the bank between 8:30 and 9:00 AM. About 8:30 AM [client A] started demanding that staff take him to the bank. Staff				weekly to discuss all incidents and investigations		
					All staff will be trained of incident reporting All staff will be trained of Abuse and Neglect and Client Rights Program Supervisor will monitor and address any issued during home visits at least three times per week	on : II es	
	1	take him as soon as they			- Program Director will	oo in	
		ey were working on. [Client A] staff and said f you. I need			monitor and address any issue		

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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCE (EACH DEFICINCY MIST BE PRECEDED BY FULL.) TAG REGULATORY OR ISE DISTRIPTION INFORMATION my chew, I'm going without you then by my d	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G300		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/13/2023
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION my chew, I'm going without you then by my d self. (Client A) then exited the house. Staff immediately grabbed the keys to the van and began following [client A]. While following [client A] staff repeatedly prompted him to get in the van due to the cold temperature and said that they would drive him to the bank. [Client A] refused to get in the van and continued walking in the direction of the bank. Once at the bank [client A] walked up to the drive thru window and cashed his check. After cashing his check [client A] still refused to get in the van with staff and instead walked to the gas station to buy himself chewing tobacco. After walking out of the gas station [client A] again refused to get in the van with staff and walked all the way home. [Client A] arrived back at the house roughly 9-37 AM. While walking [client A] was within line of sight of staff the entire time that he was away from the house. The bank that [client A] uses is 2 blocks from his home and the gas station that he went to is roughly 9 blocks from away from his home. There were no further incidents for the remainder of the day. Staff will continue to follow [client A's] BSP (Behavior Support Plan) and encourage him to use his coping skills when he is upset." A BDDS report dated 2/10/23 at 12:30 PM indicated, "On 02/10/2023 [client A] left the group home abou 12:30 pm and walked to the bank 2 blocks away without staff supervision. While at the bank [client A] attempted to access housemate [client B]s bank account using his				PIKE ST	
self. [Client A] then exited the house. Staff immediately grabbed the keys to the van and began following [client A]. While following [client A] staff repeatedly prompted him to get in the van due to the cold temperature and said that they would drive him to the bank. [Client A] refused to get in the van and continued walking in the direction of the bank. Once at the bank [client A] walked up to the drive thru window and cashed his check. After cashing his check [client A] still refused to get in the van with staff and instead walked to the gas station [client A] again refused to get in the van with staff and walked all the way home. [Client A] arrived back at the house roughly 9:37 AM. While walking [client A] asw within line of sight of staff the entire time that he was away from the house. The bank that [client A] uses is 2 blocks from his home and the gas station that he went to is roughly 9 blocks from away from his home. There were no further incidents for the remainder of the day. Staff will continue to follow [client A's] BSP (Behavior Support Plan) and encourage him to use his coping skills when he is upset." A BDDS report dated 2/10/23 at 12:30 PM indicated, "On 02/10/2023 [client A] left the group home about 12:30 pm and walked to the bank 2 blocks away without staff supervision. While at the bank [client B's] bank account using his	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
[client B's] identification card. When unable to access the account [client A] returned home. [Client A] has a BSP (Behavior Support Plan) that addresses untrustworthy behavior and elopement. Plan to Resolve: Staff will continue to follow [client A's] BSP and an investigation has been	TAG	my chew, I'm going without you then by my d self. [Client A] then exited the house. Staff immediately grabbed the keys to the van and began following [client A]. While following [client A] staff repeatedly prompted him to get in the van due to the cold temperature and said that they would drive him to the bank. [Client A] refused to get in the van and continued walking in the direction of the bank. Once at the bank [client A] walked up to the drive thru window and cashed his check. After cashing his check [client A] still refused to get in the van with staff and instead walked to the gas station to buy himself chewing tobacco. After walking out of the gas station [client A] again refused to get in the van with staff and walked all the way home. [Client A] arrived back at the house roughly 9:37 AM. While walking [client A] exhibited good pedestrian safety skills. [Client A] was within line of sight of staff the entire time that he was away from the house. The bank that [client A] uses is 2 blocks from his home and the gas station that he went to is roughly 9 blocks from away from his home. There were no further incidents for the remainder of the day. Staff will continue to follow [client A's] BSP (Behavior Support Plan) and encourage him to use his coping skills when he is upset." A BDDS report dated 2/10/23 at 12:30 PM indicated, "On 02/10/2023 [client A] left the group home about 12:30 pm and walked to the bank 2 blocks away without staff supervision. While at the bank [client A] attempted to access housemate [client B's] bank account using his [client B's] identification card. When unable to access the account [client A] returned home. [Client A] has a BSP (Behavior Support Plan) that addresses untrustworthy behavior and elopement. Plan to Resolve: Staff will continue to follow	TAG	during Site Supervisory visits Persons Responsible: Area Director, Program Director, Program Supervisor, Regiona	

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TRANSITIONAL SERVICES SUB LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECUDED BY FULL TAG (EACH DEFICIENCY MUST BY FULL TAG (EACH DEFICI	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G300		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 03/13/2023
PREFIX TAG REGILATORY OR LSC IDENTIFYING INFORMATION An investigation dated 2/22/23 indicated, "[Client A] was interviewed on 2/21/23. [Client A] stated that he eloped from the house during the afternoon on 2/10/23. [Client A] stated that he took [client B's] identification card and went to the bank and attempted to withdraw money. [Client A] stated that he identification card and went to the bank and attempted to withdraw money. [Client A] stated that he identification card and went to the bank and stempted to withdraw money. [Client A] stated that his staff [staff #4] and [staff #5] were working on 2/10/23. [Client A] stated that [staff #5] was in the office and [staff #4] was in the living room. [Client A] stated that the bank is less than two blocks from the home. [Client A] estimated that he was goring outside to vape and went to the bank. [Client A] stated that he was goring outside to vape and went to the bank. [Client A] stated that he was goring outside to vape and went to the bank. [Client A] stated that he was goring only ten minutes. [Staff #5] was interviewed on 2/21/23. [Staff #5] stated that she was working in the Martinsville Group Home on 2/10/23. [Staff #5] stated that she heard the door alarm by the front door. [Staff #5] stated that she opened the door and saw [client A] vaping on the front porch. [Staff #5] stated that she received a phone call from the bank claiming that [client A] was attempting to cash a check and had [client B's] identification. When [staff #5] got off the phone, she stated that [client A] had walked in the door and was standing in the kitchen. [Staff #5] stated that the conductor of the phone, she stated that [client A] denied leaving the home. [Staff #5] stated that the conductor of the phone and was standing in the kitchen. [Staff #5] stated that help hone. [Staff			110 W F	PIKE ST	
A] was interviewed on 2/21/23. [Client A] stated that he eloped from the house during the afternoon on 2/10/23. [Client A] stated that he took [client B's] identification card and went to the bank and attempted to withdraw money. [Client A] stated that he did not take his check and attempt to cash it. [Client A] stated that his staff [staff #4] and [staff #5] were working on 2/10/23. [Client A] stated that he told staff that he was going outside to vape and went to the bank. [Client A] stated that [staff #5] was in the office and [staff #4] was in the living room. [Client A] stated that the bank is less than two blocks from the home. [Client A] estimated that he was gone for only ten minutes. [Staff #5] was interviewed on 2/21/23. [Staff #5] stated that she was working in the Martinsville Group Home on 2/10/23. [Staff #5] stated that she heard the door alarm by the front door. [Staff #5] stated that she opened the door and saw [client A] vaping on the front porch. [Staff #5] stated that she went back to the office to complete work. [Staff #5] stated that she the staff that she received a phone call from the bank claiming that [client A] was attempting to cash a check and had [client B's] identification. When [staff #5] got off the phone, she stated that [client A] had walked in the door and was standing in the kitchen. [Staff #5] stated that client A] had walked in the door and was standing in the kitchen. [Staff #5] stated that client A] had walked in the door and was standing in the kitchen. [Staff #5] stated that client A] had walked in the door and was standing in the kitchen. [Staff #5] stated that client A] had walked in the door and was standing in the kitchen. [Staff #5] stated that the company of the phone, she stated that [client A] had walked in the door and was standing in the kitchen. [Staff #5] stated that the client A] had walked in the door and was standing in the kitchen. [Staff #5] stated	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION
identification card. [Staff #4] was interviewed on 2/21/23. [Staff #4] stated that he was in the living room when [client A] went out the door. [Staff #4] stated that [staff		An investigation dated 2/22/23 indicated, "[Client A] was interviewed on 2/21/23. [Client A] stated that he eloped from the house during the afternoon on 2/10/23. [Client A] stated that he took [client B's] identification card and went to the bank and attempted to withdraw money. [Client A] stated that he did not take his check and attempt to cash it. [Client A] stated that his staff [staff #4] and [staff #5] were working on 2/10/23. [Client A] stated that he told staff that he was going outside to vape and went to the bank. [Client A] stated that [staff #5] was in the office and [staff #4] was in the living room. [Client A] stated that the bank is less than two blocks from the home. [Client A] estimated that he was gone for only ten minutes. [Staff #5] was interviewed on 2/21/23. [Staff #5] stated that she was working in the Martinsville Group Home on 2/10/23. [Staff #5] stated that she heard the door alarm by the front door. [Staff #5] stated that she opened the door and saw [client A] vaping on the front porch. [Staff #5] stated that she went back to the office to complete work. [Staff #5] stated that other staff [staff #4] was cleaning and assisting other clients in the living room. [Staff #5] stated that she received a phone call from the bank claiming that [client A] was attempting to cash a check and had [client B's] identification. When [staff #5] got off the phone, she stated that [client A] had walked in the door and was standing in the kitchen. [Staff #5] stated that [client A] denied leaving the home. [Staff #5] stated that [client A] denied having [client B's] identification card. [Staff #4] was interviewed on 2/21/23. [Staff #4] stated that he was in the living room when [client			

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	ipleted 13/2023
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC			110 W	ADDRESS, CITY, STATE, ZIP PIKE ST NSVILLE, IN 46151	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	[Staff #4] stated tha home. [Staff #4] sta into the home after [Staff #4] stated tha the bank called and [Staff #4] stated tha [client B's] identific	and went back into the office. It he continued cleaning the sted that he saw [client A] walk approximately ten minutes. It [staff #5] informed him that stated [client A] was there. It [client A] denied having station card.				
	stated that [staff #5] elopement. [Staff #6] representative from [client A] attempted [client B's] identified that [client A] denied identification at first attempt to withdraw [client A] returned not return the check A] gets the mail at the check then. [Staff #6]	notified him of [client A's] fo] stated that he spoke with a the bank and they stated that It to cash [client B's] check with sation card. [Staff #6] stated and having [client B's] t but admitted to using it to money. [Staff #6] stated that the identification card but did a. [Staff #6] stated that [client times and believes he took the fo] stated that he is attempting ity to cancel the check and get				
	stated that he was n his identification ca B] stated that he wi keeping. [Client B]	ot aware of [client A] taking rd until it was returned. [Client IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII				
	[client B's] identific and attempted to ca	bstantiated that [client A] took ration and Social Security check sh it at the bank, it is also client A] eloped from the home en minutes.				
	Recommendations:	All staff retrained on [client				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G300		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/13/2023		
	PROVIDER OR SUPPLIER		110 W	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) OMPLETION DATE
	[client A] outside w with [client B] about and will assist in se request a new Social and will reimburse. Staff will observe in ensure any individual Completed by: [Regard The review of record address staff neglect that client A eloped indicated recomment investigator were not at 10:00 AM. The Aconducted by a prevad indicated the all investigated. The Ashould first look into neglectful in caring indicated recommendations from the American for the Qualified Intellation (QIDP)/Program Diagram 10:377/23 at 10:00 AM investigation was not stated "recommendations from the American Investigation was not stated "recommendations from the American Investigation was not stated "recommendations trained investigation was not stated "recommendation as possible so again."	AD) was interviewed on 3/7/23 AD stated the investigation was vious program director. The legation was not thoroughly D stated "investigations o whether or not staff were for the clients." The AD indations should be developed				

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

PRINTED: 05/04/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	ILDING	nstruction <u>00</u>	(X3) DATE S	ETED	
		15G300	B. WI	NG	_	03/13/	2023
	ROVIDER OR SUPPLIEF			110 W F	DDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151		
(X4) ID	SHMMADV	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	reviewed on 2/28/2	3 at 12:30 PM. The review					
	indicated the follow	ving:					
	A BDDS report dati indicated, "On 02/0 eating his lunch he he was still hungry, and [client B] begand and peers. [Client B] over the ash tray on multiple times that home. Staff informore property that they we the staff were the or moment. About 12: property walking in station that he enjoy that time staff called local police departing [client B] at the near with [client B] and and then drove him incidents for the rere had a change to his minute alone time of where local law enficient B] leaves the B] has good pedestrisk when walking it Resolve: Staff will BSP." A BDDS report datindicated, "On 02/1 woke up from a nagunknown reasons. A went upstairs to [client worth of change and and left the house. Staff will be the staff	ed 2/5/23 at 12:35 PM 5/2023 after [client B] finished became upset and stated that Staff offered him more food in yelling and cussing at staff be also slammed doors, knocked if the porch and informed staff the was going to leave the ed [client B] that if he left the would have to call the police as inly staff at the house at the 35 PM [client B] left the if the direction of a nearby gas we going to to get drinks. At id management and then call the ment for assistance. Police met reby gas station. Police spoke bought him a fountain drink home. There were no further mainder of the day. [Client B] BSP that removed his 30 fue to misuse and put in place forcement to be notified when the home unsupervised. [Client trian safety skills and is not at in the community. Plan to continue to follow [client B] and became agitated for About 8:20 pm [client B] then tent A's] room and stole \$1 d then went back down stairs Staff called [city] police for					
	assistance to locate	[client B] after he eloped due					
			1				

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/13/2023
	PROVIDER OR SUPPLIER		110 W I	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	(X5) COMPLETION DATE
	to there being one s returned [client B] that a BS towards others, dest disruptive behavior uncooperative behavior on 02/20/2023 to re and is currently awa investigation is being money." A BDDS report data indicated, "On 2/20 became agitated for house. Staff following as station near the way into the station attendant out of the came to the station [client B] was calm and was transported that addresses aggree destructive (sic) to psocially offensive behavior, elopement Plan to resolve: Staff BSP and interated health and safety." An investigation da B] was interviewed that he became upser money for a drink a stated that he walke [staff #10] attempted Group Home. [Client him at the gas station at the gas station as the gas station and the gas station at the gas station and the gas station at the gas station and the gas and the	taff on shift at the time. Police to the house about 8:50 pm. P that addresses aggression			

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 03/13/2023
	PROVIDER OR SUPPLIER		110 W	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	D BE COMPLETION
TAG	station worker aske to his staff. [Client and went in the gas he did not push the threats towards ther a drink while in the [Client B] stated the staff and began wal [Client B] stated the spoke to him about without permission returned back to the with the police. [Staff #5] was interstated that she was with the other indivibrated that she notice station and watched stated that she did in himself into the gas when [Client B] left ride home. [Staff #5] [client B] speaking to him about not lead permission. [Staff #5] [client B] speaking to him about not lead permission. [Staff #6] from DSP [staff #6] from DSP [staff #1] group home and [staff was refusing to return the gas station after stated that it was recalled and spoke to	d him not to enter and to listen B] stated that he ignored them station. [Client B] stated that gas station staff nor make any in. [Client B] stated that he got gas station and paid for it. In the refused to ride home with king back to the group home. In the police stopped him and into leaving the group home [Client B] stated that he is group home after speaking wiewed on 2/22/23. [Staff #5] driving the van on an outing iduals in the home. [Staff #5] ed staff [staff #10] at the gas [Client B] go inside. [Staff #5] ot witness [Client B] force station. [Staff #5] stated that it the gas station, he refused a significant stated that she witnessed with the police and they spoke wing the group home without [Staff #10] was attempting to the group home without stated that he received a report [1] that [client B] eloped from the aff #10] was attempting to to return to the home. [Staff #6] ported that the police were [client B] while he was ff #6] stated that no further	TAG	DEFICIENCY	DATE

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	T OF DEFICIENCIES DF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 00	(X3) DATE COMPL 03/13	LETED
	ROVIDER OR SUPPLIER		110 W I	ADDRESS, CITY, STATE, ZIP CO	D	
TRANSIT	IONAL SERVICES	SUB LLC	MARTIN	NSVILLE, IN 46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	incidents were report involving [Client B]	rted to him that night .				
	#11] stated that he was the night of 2/20/23 witnessed [client B] #10], DSP, followed stayed at the home was present. [Staff #11] incident to [Staff #6 #11] stated that staff defiant and entered permission. [Staff # that [client B] refuse were called. [Staff # not have any further [Staff #10], DSP, w [Staff #10], DSP, w [Staff #10] stated the eloped from the hor stated that she attemback to the home. [S [Client B] refused, s [Staff #10] stated the asked [staff #10] if [Staff #10] stated the staff that she will at he was there without stated when [client be was the staff #10] stated the entered the gas stati #10] stated that the call the police in which stated that [client B] contact with the gas staff but it was unin that [client B] refuse	as interviewed on 2/27/23. [Staff vas working in the home on . [Staff #11] stated that he leave the home and [Staff dhim. [Staff #11] stated that he with remaining individuals stated that he reported the .], Program Supervisor. [Staff f told him that [Client B] was the gas station without 11] stated that staff told him ed a ride home and the police that is the content of the remaining individuals stated that [Client B] did incidents that evening. as interviewed on 2/27/23. at [client B] became upset and the on 2/20/23. [Staff #10] and the gas station. at the gas station tempt to get [client B] home as the permission. [Staff #10] B] arrived the gas station staff and to go home with staff. at [client B] ignored them and on and bought a drink. [Staff gas station staff asked her to such she did so. [Staff #10] I may have made slight station tentional. [Staff #10] stated ed to be transported home. at [staff #5], DSP, arrived in				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G300		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 03/13/2023
	PROVIDER OR SUPPLIER TIONAL SERVICES SUB LLC	110 W F	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	the van to assist but [client B] ignored her as well. [Staff #10] stated that while [client B] was walking home, police officers stopped him and spoke with him about not leaving the home without permission. [Staff #10] stated that [Client B] returned home without further incident. Conclusion: It is substantiated that [client B] eloped from the home, it is unsubstantiated that [client B] shoved the gas station staff. Recommendations: Staff will be trained on updated BSP that includes alone time each day for [client B], staff will be trained on incident reporting investigation. Competed by [Regional Director] 2/27/23." The review indicated there was no investigation for the 2/5/23 and 2/19/23 incidents of elopement and theft of client A's money. The review indicated the investigation did not address if staff followed client B's BSP to address his behavior of agitation which led up to the elopement. The Area Director (AD) was interviewed on 3/7/23 at 10:00 AM. The AD indicated there was no investigation for client B's elopements on 2/5/23 and 2/19/23. The AD stated, "I don't have one (investigation) for those incidents." The AD stated the investigation was conducted "by the Regional Director for [client B's] last elopement." The AD indicated the allegation was not thoroughly investigated. The AD stated "incidents of elopement should address whether or not the client's BSP was followed by staff." The AD stated, "Abuse, neglect, exploitation (ANEM) allegations, pretty much all incidents in some form require an investigation." The AD stated there have been 3 different Program Directors in the last			
	4 months and she just took over as AD so "things			

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	ROVIDER OR SUPPLIER		110 W	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	missed or can't be for investigations shoul such as "training, for observations."	•			
	(QIDP)/Program Di 3/7/23 at 10:00 AM investigations are "Colevel, we handle, as comes in and facilitathe investigation shoor not staff neglecte QIDP/PD stated "the investigation." T "corrective measure happening again" ar should always be put	s help keep the incident from ad "corrective measures			
W 0159	9-3-2(a) 483.430(a)				
Bldg. 00	be integrated, coo a qualified intellect who-Based on observation interview for 3 of 3 C) and three addition Qualified Intellectual (QIDP) failed to interview for 3 of 3 communication systems of the clients' program communication systems group home and the program; failed to expectives were imposed in the control of the	the treatment program must redinated and monitored by tual disability professional on, record review and clients in the sample (A, B and nal clients (E, G and H), the al Disabilities Professional egrate, coordinate and monitor plans to ensure there was a tem in place between the facility-operated day insure client E's training elemented, and staff had a copy or Support Plan and Active in the home.	W 0159	- Home staff will be train on completing the communications and ensuring it is taken. Day Program daily - Day Program staff will trained on completing communication book - Specifically for Client E Behavior Support Plan, Object and Activity Schedule will be implemented in the home - Program Director and Activity and Director and Activity Schedule will be implemented in the home -	ation to be E, ptives,

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPL	
		15G300	B. WING		03/13/	2023
	ROVIDER OR SUPPLIER		110 W F	NDDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID BROWDER'S N. AN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	T.C.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	16	DATE
	sample (A, B and C and H), the QIDP fa communication syst group home and the program. 2) Please refer to W (client E), the QIDF copy of client E's B home. 3) Please refer to W (client E), the QIDF training objectives with the QIDF training objective	250. For 1 additional client Pailed to ensure there was an		Director will be trained on ensuall proper documentation is completed and in the home - Program Supervisor wi monitor at least three times weekly during home visits - Program Director will monitor and address any issue the home during weekly Site Supervisory visits Persons Responsible: Area Director, Program Director, Program Director, Program Supervisor, Behavior	ll es in	
	9-3-3(a)					
W 0248 Bldg. 00	be made available including staff of c with the client, and the client is a mind	ent's individual plan must to all relevant staff, ther agencies who work d to the client, parents (if or) or legal guardian.				
	review for 1 additio	on, interview and record nal client (client E), the facility f had a copy of client E's lan in the home.	W 0248	 Management will ensur that all plans including Behavior Support Plans for every client in the home Specifically for Client E management will ensure that Behavior Support Plan and Acceptable 	or are ,	04/28/2023

Observations were conducted in the group home

Treatment schedule is available for

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G300		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/13/2023	
	PROVIDER OR SUPPLIE		110 W	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF on 2/28/23 from 4: 3/1/23 from 6:30 A at 4:50 PM, client I with the door close prompted to the dir #7. At 5:15 PM, af his room and close came out of his roo the bathroom by sta	STATEMENT OF DEFICIENCIE SCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION 45 PM until 7:45 PM and on M through 9:10 AM. On 2/28/23 E was in his room lying in bed d. At 5:05 PM client E was hing room for supper by Staff ter eating, client E went back to d the door. At 6:15 PM, client E om and was prompted to go to aff #7. When finished, client E om with the door closed. Client oom until the end of the	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) staff in the home - Program Director and A Director will be trained on ens all clients' plans are available staff use in the home - Program Supervisor w monitor at least three times weekly during home visits - Program Director will monitor at least once weekly during Site Supervisory visits Persons Responsible: Area	Area suring for
	bed with the door of until the end of the without staff promports. Client E's record was PM. Client E's 10/2 (BSP) indicated, ". completes day progare [Client E] requires throughout the day by using simple was [Client E] needs as activities of daily list swimming, writing taking a bath, and of become obsessive extreme physical agothers, and propert E's] behaviors occur over something, who read to be property, disruptive These behaviors ty results of [client E]	AM client E was in his room in closed and remained in his room observation at 9:10 AM pering him to an activity. as reviewed on 3/2/23 at 2:00 at 2:22 Behavior Support Plan at Client E is not employed, and gramming at the group home. Constant supervision are constant supervision. [Client E] can communicate and phrases, and gestures. Sistance with completing are in the van, jumping, exercising. [Client E] can cover things, which can result in a gression towards self and by destruction. Many of [client are as a result of him obsessing mether he has access to the item tengages in aggression towards wards others, destructive to be behavior, and elopement. Pically occur in a chain and are obsessing over access to client E] enjoys staff interaction,		Director, Program Director, Program Supervisor, Regiona Director	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	r í	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 03/13/	ETED
	PROVIDER OR SUPPLIER			110 W F	NDDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	TE	(X5) COMPLETION DATE
	but typically does in attention throughou reducing maladaptirengaged in enrichinday to reduce incide behaviors" Staff #5 was intervistaff #5 stated client E "destroys e out in the communi" gets out in the communi "gets out in the communi "gets out in the communi that the community of the community of the community of the community. Staff #7 stated client E out in the community of this room, occasion that the community of the community of the community of the community. Staff #2 stated client E that the community of the community. Staff #4 doesn't go inside be station] and [restaut thousands of dollars client E "likes to go likes "van rides, especial that the community of t	ot ask for it. Giving [client E] t the day will assist with we behaviors. Keep [client E] g activities throughout the ents of maladaptive ewed on 2/28/23 at 6:30 PM. It E is "home everyday" and by program. Staff #5 stated verything" and is "2 to 1 when ty." Staff #5 stated client E munity a few times a week" ewed on 3/1/23 at 6:30 AM. It E "went to day program for a stimulated him and he had aff #7 stated staff "try" to get community "he likes the park, he loves to swing and play ewed on 3/1/23 at 8:00 AM. attempt to get him to come out conally we can get him to sit on stated "it's difficult to get him coom, he will come out to eat, if ts to do, he won't do it" and h him one time for 2 hours." It E "just lays in his bed". Staff cinda" goes on outings in the 2 elaborated and stated "he cause he's destroyed the [gas rant] in the past causing s of damage." Staff #2 stated to the park to swing" and he pecially speed bumps." Staff #2 " staff will take client E "to					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 03/13/2023
	PROVIDER OR SUPPLIER		110 W	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	3/1/23. The CI indicavailable in the hom plans at the office, v [client E] had a bad his plan to see what down." On 3/7/23 at 10:00 interviewed. The AD in have been available On 3/7/23 at 10:00 interviewed. The RI plans here at the office to update all the plans here at the office update	view (CI) was conducted on cated client E's plans were not the. The CI stated "they had our we didn't have the plans when behavior. I wanted to look at else we could try to calm him AM the Area Director (AD) was D stated "we had the clients' fice so they could be indicated client E's plan should to staff. AM the Regional (RD) was D stated "we had the clients' fice because we had a meeting ins." The RD indicated client e been available to staff.			
W 0240	9-3-4(a)				
W 0249 Bldg. 00	formulated a clien each client must retreatment program interventions and number and frequachievement of thindividual program	erdisciplinary team has t's individual program plan, eceive a continuous active n consisting of needed services in sufficient ency to support the e objectives identified in the n plan.			
	interview for 1 addi	on, record review and tional client (client E), the sure client E's training olemented.	W 0249	The IDT will meet to discuss Client E's objectives active treatment schedule to ensure they are appropriate Staff will be trained on updated objectives for Client Program Director and	any

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	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	(X2) MULT A. BUILL B. WING	DING	nstruction 00	(X3) DATE S COMPL 03/13/	ETED
	PROVIDER OR SUPPLIEF			110 W F	DDRESS, CITY, STATE, ZIP COD PIKE ST ISVILLE, IN 46151		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG	Observations were on 2/28/23 from 4:4 3/1/23 from 6:30 A at 4:50 PM, client F with the door closed prompted to the din #7. At 5:15 PM, afth his room and closed came out of his room the bathroom by state went back to his room E remained in his room observation period			ΓAG	Program Supervisor will be trae on ensuring objectives and all active treatment are being completed for all clients in the home - Staff will be trained on active treatment and following objectives for all clients in the home - Program Supervisor will monitor at least three times weekly during home visits - Program Director will		DATE
	bed with the door c until the end of the without staff promp Client E's record wa	M client E was in his room in losed and remained in his room observation at 9:10 AM oting him to an activity. as reviewed on 3/2/23 at 2:00 //22 Behavior Support Plan			monitor and address any issue the home at least once weekly during Site Supervisory visits		
	(BSP) indicated, " completes day prog [Client E] requires throughout the day. by using simple wo [Client E] needs assactivities of daily li swimming, writing, taking a bath, and e become obsessive cextreme physical agothers, and property E's] behaviors occur. Client E's 4/28/22 I indicated he had the "-Daily, [Client E] med pass.	[Client E] is not employed, and ramming at the group home. constant supervision [Client E] can communicate rds and phrases, and gestures. sistance with completing ving. [Client E] enjoys riding in the van, jumping, xercising. [Client E] can over things, which can result in the gression towards self and of destruction. Many of [client er as a result of him obsessing." Individual Support Plan (ISP) the following training objectives: will go to the dining room for thicipate in a community outing at			Persons Responsible: Area Director, Program Director, Program Supervisor		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G300		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COM	ie survey ipleted 13/2023	
	PROVIDER OR SUPPLIER		110 W I	ADDRESS, CITY, STATE, ZIP COI	D	
TRANSI	FIONAL SERVICES	SUBILIC	MARIII	NSVILLE, IN 46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO!) CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
IAU	-Daily, [Client E] whis communication -Bimonthly, [Client account and sign hither account and he washerDaily, [Client E] with mouth with a napking staff #5 was intervited as not attend a dark of a client E "destroys expected out in the community gets at fact that over huge behaviors". Staff #7 stated are "difficult because wants to do." Staff #2 was intervity staff #2 was intervity staff #2 indicated chis dirty clothes in the community gets and wiping his mounts and wiping his moun	will practice one sign to increase with others. E] will withdraw from his bank is name to the withdrawal. Will put his clothes and bedding will take a drink and/or wipe his in in between bites of food." Ewed on 2/28/23 at 6:30 PM. It E is "home everyday" and many program. Staff #5 stated everything" and is "2 to 1 when ty." Staff #5 stated client E munity a few times a week" Staff #5 stated for client E's will do things with prompting,	IAU			DATE

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 03/13/2023
	ROVIDER OR SUPPLIER		110 W	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
W 0250 Bldg. 00	doesn't go inside be station] and [restaur thousands of dollars client E "likes to go likes "van rides, esp stated "on occasion" [restaurant], it's his On 3/7/23 at 10:00 interviewed. The Al should be followed. should follow client On 3/7/23 at 10:00 interviewed. The RI training with staff o indicated client E's go-3-4(a) 483.440(d)(2) PROGRAM IMPLIATE The facility must does consider that outling the state of the schedule that outling the state of the schedule for client Interviewed. The review for 1 addition failed to ensure them schedule for client Interviewed. The schedule for client Interviewed for 1 addition failed to ensure them schedule for client Interviewed. The schedule for client Interviewed for 1 addition failed to ensure them schedule for client Interviewed for 1 addition failed to ensure them schedule for client Interviewed for 1 addition failed to ensure them schedule for client Interviewed for 1 addition failed to ensure them schedule for client Interviewed for 1 addition failed to ensure them schedule for client Interviewed from 6:30 Al at 4:50 PM, client E with the door closed	AM the Area Director (AD) was D stated "the clients' plans" The AD indicated staff E's plan. AM the Regional (RD) was D stated "we need to do more in clients' plans." The RD plan should be followed. EMENTATION develop an active treatment ines the current active in and that is readily we by relevant staff. On, interview and record inal client (client E), the facility we was an Active Treatment.	W 0250	- The IDT will meet to discuss Client E's objectives a active treatment schedule to ensure they are appropriate - Staff will be trained on updated objectives for Client - Program Director and Program Supervisor will be trained on ensuring objectives and all active treatment are being completed for all clients in the home - Staff will be trained on	any E ained I
	prompted to the din	ing room for supper by Staff		- Staff will be trained on	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G300		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 03/13/2023	
	PROVIDER OR SUPPLIEF		110 W	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF #7. At 5:15 PM, aft his room and closed	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION er eating, client E went back to I the door. At 6:15 PM, client E m and was prompted to go to	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY) active treatment and following objectives for all clients in the home	DATE
	the bathroom by sta went back to his roo E remained in his ro observation period	off #7. When finished, client E om with the door closed. Client com until the end of the at 7:45 PM.		Program Supervisor w monitor at least three times weekly during home visits Program Director will monitor and address any issues.	es in
	bed with the door c until the end of the without staff promp	M client E was in his room in losed and remained in his room observation at 9:10 AM ting him to an activity.		the home at least once weekl during Site Supervisory visits	y
	PM. Client E's 10/2 (BSP) indicated, " completes day prog [Client E] requires of throughout the day. by using simple wo [Client E] needs assactivities of daily liswimming, writing, taking a bath, and e become obsessive coextreme physical agothers, and property E's] behaviors occu	as reviewed on 3/2/23 at 2:00 /22 Behavior Support Plan .[Client E] is not employed, and ramming at the group home. constant supervision [Client E] can communicate rds and phrases, and gestures. distance with completing ving. [Client E] enjoys riding in the van, jumping, exercising. [Client E] can over things, which can result in a gression towards self and of destruction. Many of [client r as a result of him obsessing."		Persons Responsible: Area Director, Program Director, Program Supervisor	
	indicated he had the "-Daily, [Client E] med pass[Client E] will part least 3 times per we -Daily, [Client E] w his communication -Bimonthly, [Client account and sign hi	rill practice one sign to increase			

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	r í	JILDING	NSTRUCTION 00	(X3) DATE COMPI 03/13	LETED
	PROVIDER OR SUPPLIEI			110 W F	DDRESS, CITY, STATE, ZIP COD PIKE ST ISVILLE, IN 46151		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N BE PRIATE	(X5) COMPLETION
TAG	in the washerDaily, [Client E] v	vill take a drink and/or wipe his n in between bites of food."		TAG	DEFICIENCY		DATE
	The review indicated client E did not have an Active Treatment schedule.						
	Staff #5 stated clien does not attend a da client E "destroys e out in the communi "gets out in the con and he "loves ball".	tewed on 2/28/23 at 6:30 PM. at E is "home everyday" and by program. Staff #5 stated everything" and is "2 to 1 when ty." Staff #5 stated client E annunity a few times a week" Staff #5 stated for client E's will do things with prompting, ne mood."					
	Staff #7 stated clien while but that over huge behaviors". So client E out in the c van rides, fast food ball." Staff #7 state	tewed on 3/1/23 at 6:30 AM. In E "went to day program for a stimulated him and he had aff #7 stated staff "try" to get ommunity "he likes the park, the loves to swing and play d client E's training objectives see he will only do what he					
	Staff #2 indicated of his dirty clothes in and wiping his mou stated "we attempt room, occasionally porch." Staff #2 stated client E "just stated client E "kincommunity. Staff #	lewed on 3/1/23 at 8:00 AM. lient E has goals of "putting the hamper, taking his meds, ath when eating." Staff #2 to get him to come out of his we can get him to sit on the ted "it's difficult to get him to m, he will come out to eat, if it to do, he won't do it." Staff #2 lays in his bed". Staff #2 da" goes on outings in the 2 elaborated and stated "he ecause he's destroyed the [gas					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/13/2023
	PROVIDER OR SUPPLIER		110 W	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	(X5) COMPLETION DATE
	thousands of dollars client E "likes to go likes "van rides, esp stated "on occasion" [restaurant], it's his On 3/7/23 at 10:00 interviewed. The A specialist worked w company, another b but he resigned 4 w open at the time. The have an active treats should follow [clier schedule." [Behavioleft, they hired [BS] On 3/7/23 at 10:00 interviewed. The Qi	rant] in the past causing of damage." Staff #2 stated to the park to swing" and he recially speed bumps." Staff #2 staff will take client E "to favorite." AM the Area Director (AD) was D indicated a behavioral ith client E but she left the ehavioral specialist was hired eeks ago, leaving that position are AD stated client E "should ment schedule" and "staff at E's] active treatment for Specialist (BS) #1] recently #2], he resigned 4 weeks ago." AM the QIDP/PD was IDP/PD stated "all clients we treatment schedule that			
W 0331 Bldg. 00		CES rovide clients with nursing ance with their needs.			
	Based on observation interview for 3 of 3 and C), plus 4 additional and H), the facility's ensure medications B, C, D, E, F and H expired medications to ensure all medications	on, record review and sampled clients (clients A, B ional clients (clients D, E, F is nursing services failed to were in the home for clients A, failed to ensure there were not in the home for client C, failed attions had a label for clients F ensure injection sites were	W 0331	- Nurse will complete a medication review in the hom ensure that all medications are present, no medications are expired, all medications are labeled, and that injection site are documented - Program Supervisor w trained on ensuring all medications are present and notify nursing and managements.	re es vill be

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

PRINTED: 05/04/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 15G300	A. BUILDING B. WING	00 00	COMPLETED 03/13/2023
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD PIKE ST	
TRANSIT	FIONAL SERVICES	SUB LLC		NSVILLE, IN 46151	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
IAU	Findings include: Observations were on 2/28/23 from 4:43/1/23 from 6:30 Al at 7:00 AM a bottle client F had no label on it that indicated iron had no label on meclizine (dizziness had an expiration day of Gas-X simethicon with no label, a box no label, a bottle of label and a bottle of "staff only" hand with A had an order for a Medication Administivas not signed off become was documented. Stoward off as given laws documented. Stoward off as given laws documented. Stoward off as a PRN or stings". An epipen from and staff #2 was una client H gets the epi bee" and "I know it the program supervimeds." At 8:00 AM indicated he had an "Victoza (for diabet that was initialed by site the staff adminiput it in his belly, ei side, we rotate."	conducted in the group home 5 PM until 7:45 PM and on M through 9:10 AM. On 2/28/23 of Mylanta (stomach) for I present and had handwriting [client F] 3/30/22", a bottle of it for client H. At 7:15 AM 30 is) 12.5 mg tablets for client C the of "10-22". There was a box the 125 mg chewable, 14 tabs, of dulcolax 5 mg, 6 tablets with tylenol 500 mg tablets with no ibuprofen 200 mg that had ritten on it. At 8:00 AM, client a supplemental shake on his stration Record (MAR) that by staff. Staff #2 stated "his have those, he hasn't had years." Client A's MAR had B12 injections that was by staff, but no injection site aff #2 stated "he tells you rotate the site." Client H's der for an epipen for "bee for client H was not available able to locate it. Staff #2 stated pen "if he gets stung by a was getting ready to expire, sor was trying to get our the MAR for client H order for an injection of es) 1.8mg subcutaneous daily" restaff but did not indicate the stered it. Staff #2 stated "we ther the left side or the right	IAU	any issues with medications of All staff will be trained of medication administration Program Supervisor with monitor at least three times perweek during home visits Program Director will monitor and address any issue the home at least one time perweek during Site Supervisory Nurse will monitor at letwice weekly during home visits Persons Responsible: Area Director, Program Director, Program Director, Program Supervisor, Nurse	ccur on II er es in r visits ast

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G300	B. W	ING		03/13/2023	
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER			110 W F			
TDANCIT	TONAL SERVICES	CHRILO					
TRANSII	TIONAL SERVICES	SOB LLC		MARTIN	NSVILLE, IN 46151		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Services (BDDS) r	eports were reviewed on					
	2/28/23 at 12:30 PM	I. The review indicated the					
	following:						
	A BDDS report date	ed 10/2/22 at 8:00 AM					
	_	1/2022 it was brought to					
	· ·	Director (PPD) [PPD's]					
	. , .	t E] had not been administered					
	_	cations: Cetirizine (for allergies)					
	-) tab (tablet) (last administered					
	` •	cusate (stool softener) 240 MG					
		ed on 10-07-2022), Linzess					
	`	cap (missed dosages					
		10-2022), Xifaxan (antibiotic for					
		tab (last administered on					
		nacy has sent refill request					
		Care Provider (PCP)] who is					
		t request was sent on					
	-	[Program Director] went to					
		poke with office staff and left a					
		eation refills. PCP office stated					
		busy and that it would take					
		o send the refill order to the					
		[] isn't showing any adverse					
	* * -	g administered the listed					
	medications.	, daministered the fisted					
		rogram Director] will continue					
	_	CP's] office daily about refill					
	orders being sent to	= -					
	January State of the Control of the	£					
	A BDDS report date	ed 10/2/22 at 8:00 am indicated,					
	_	was brought to [Program					
		that [client C] had not been					
	_	lowing medications:					
		sychotic) 20 mg tablet (last					
		3/2022), Lamotrigine (for					
		(last administered on					
		ultivitamin (supplement) tablet					
	· · · · · · · · · · · · · · · · · · ·	2022). [Pharmacy] sent refill					
		ient C's] PCP, [PCP]. These					
	request orders to [et	ien objioi, [i oi]. These					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/13/2023
	PROVIDER OR SUPPLIEF		110 W I	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	were sent again on went to [PCP's] offileft a list of needed office stated they hat take up to 72 hours the pharmacy. [Clie any adverse effects medications. [PCP's DSP [Staff #2]. The would do her best to [pharmacy] by the control of the pharmacy] in [City spoke with a call ce [client C] is not in the Plan to Resolve: [Pato follow up with [Prefill requests being Director] will continue regarding the Ariping Additionally, [Prognightly medication and PRN (as needed which will alert stated as a proper data indicated, "On 11/1 medication audit at discovered that on given his evening in Trospium Chloride The program nurse discovered. The program nurse discovered. The program noted up to the times	10/10/2022. [Program Director] ce, spoke with office staff, and medication refills. The PCP's ave been busy, and it could for refill orders to be sent to ent C] has not been showing due to the missed in nurse called and spoke with enurse, [Nurse], stated she of get the order sent to end of the day. Additionally, aripiprazole is not prescribed R (medication administration prazole is prescribed by Health Nurse Practitioner, State]. [Program Director] inter representative who stated			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/13/2023
	PROVIDER OR SUPPLIER		110 W	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	SE COMPLETION
	safety. Plan to Resolve: The continue to monitor safety. The program medication observa A BDDS report date indicated, "On 11/1 B] is out of the folked HCL (for anxiety) 2 taken 1 x (time) dain home staff, and [PE requesting the medication the group home." A BDDS report date indicated, "On 11/1 C] is out of the folked indicated	e Mentor staff and nurse will [client D] for health and nurse will compete a tion and training with staff." ed 11/15/22 at 7:52 PM 5/22, [PD] was informed [client owing medication; Guanfacine 20mg. This medication is to be ly per [PCP]. [Pharmacy], group D] have called [PCP] office cation be refilled. Plan to continue to reach out to [PCP's] ication is refilled and brought		CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE
	indicated, "On 11/1 H] is out of the follo (supplement) 1,000 medication is to be [Pharmacy], group called [PCP's] office refilled. Plan to Res reach out to [PCP's]	ed 11/15/22 at 7:52 PM 5/22, [PD] was informed [client owing medication: Vitamin B 12 mcg (micrograms). This taken 1 x daily per [PCP]. home staff, and [PD] have e requesting the medication be solve: [PD] will continue to office until the medication is to the group home."			

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	TOF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 15G300	(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 03/13/2023
	PROVIDER OR SUPPLIER FIONAL SERVICES SUB LLC	110 W I	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	A BDDS report dated 11/27/22 at 8:00 PM indicated, "On 11/27/2022 staff was conducting a medication audit, and it discovered that on 11/27/2022 several individuals did not receive their medications. [Client D] was not given his evening medication consisting of Olanzapine (antipsychotic) 20 mg. [Client C] was not given Rosuvastatin (for high cholesterol) 5 mg, [client A] was not given his Invega (antipsychotic) 4.5 mg and [client E] was not given Clozapine (antipsychotic) 200 mg, Linzess (for abdominal symptoms) 145 mg and Xifaxan (antibiotic for the intestines). The program nurse was notified as soon as it was discovered. The program nurse instructed staff to monitor all individuals for signs of adverse side effects of the missed evening medication and none were noted up to the time of this report. Staff and nurse will continue to monitor for health and safety. Plan to Resolve: The Mentor staff and nurse will continue to monitor all for health and safety. The program nurse will complete a medication observation and training with staff." A BDDS report dated 2/7/23 at 8:00 AM indicated, "On 02/07/2023 while Program Director was completing an audit of the Medical Administration Record at the home it was discovered that [client C] was out of the following medication Lamotrigine (for mood) 25 MG Tablet. According to the record [client C] had not been administered these medications from the 1st through the 7th of February. [Client C] has an appointment scheduled with his Psych on February 22nd to have a script sent to the pharmacy. [Client C] has not experienced any adverse effects from not being administered medications. Staff will check with [Pharmacy] to ensure scripts were received and filled. An investigation has been initiated to			

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/13/2023
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
TRANSIT	IONAL SERVICES	SUB LLC		PIKE ST NSVILLE, IN 46151	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE CONTINUE
TAG		LSC IDENTIFYING INFORMATION of the medication errors."	TAG	DEFICIENCY	DATE
	determine the cause	of the medication errors.			
	A BDDS report date	ed 2/7/23 at 8:00 AM indicated,			
	"On 02/07/2023 wh	ile Program Director was			
		of the Medical Administration			
		it was discovered that [client			
	-	llowing medications, Docusate			
	CAL 240 MG Soft	gel (stool softener), MG Tablet (supplement),			
		4 MG Capsule (for enlarged			
		an 550 MG Tablet (antibiotic			
	-	According to the record [client			
		ninistered these medications			
	from the 1st through the 7th of February. [Client				
		n 02/07/2023 and they sent in			
		or the above medications.			
		xperienced any adverse effects			
	_	inistered medications. aff will check with [Pharmacy]			
		re received and filled. An			
	-	en initiated to determine the			
	cause of the medica				
	The review of the fo	acility's BDDS reports			
		B, C, D, E and H did not			
		ations as prescribed by the			
	physician.	•			
	Stoff #7 : :	ewed on 3/1/23 at 7:15 AM.			
		(DSPs) order the meds, most			
		they are not here when we are			
	passing meds we ca	•			
		view (CI) was conducted on			
		ed "we call the doctor's office			
		ve call to let management know			
		ble." The CI went on to say "I			
		we don't have the tools we			
	need to do our jobs,	such as meds.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G300	B. W.	ING	<u> </u>	03/13	/2023
				CTREET	DDRESS SITN STATE ZIR COD		
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
TDANCIT	TIONIAL SERVICES	CLIPILLO			PIKE ST NSVILLE, IN 46151		
TRANSH	TIONAL SERVICES	SUB LLC		WARTIN	NSVILLE, IN 46151		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	The Area Director ((AD) was interviewed on 3/7/23					
	at 10:00 AM. The A	AD stated "all staff are trained					
	in the mandatory Co	ore A and Core B in new hire					
	orientation and then	annually." The AD stated "I					
	just took over as the	e AD, I know the last AD					
	started doing audits	of medications and the					
	quality department	completed an investigation so					
		ll staff on Core A and Core B."					
	The AD stated the o	clients' medications "should be					
	administered as pre-	scribed."					
	, , ,	tered Nurse (RN) was					
	interviewed on 3/7/23 at 11:00 AM. The RN stated						
		ould have a label with the					
		edication information" and					
		ecking for expired meds and					
	_	ne RN stated staff should					
	1	sites by "noting it on the					
		licated all staff are Core A and					
		stated "staff in the home					
	1	e sure the clients medications					
		ore they run out." The RN					
		could have had severe issues"					
		their prescribed medications.					
		ats' medications should always					
		e physician's orders "should					
	always be followed	."					
	THE CONTRACT	Di da					
		Direct Support Professional					
	l ` ′	ed 6/9/2020 was reviewed on					
		M. The review indicated the					
	_	cation errors are any error while					
	_	cations that results in incorrect					
		on or an incorrect omission of a					
		alt of not following the 6 rights					
		nistration. Medication errors					
		cation omission without a					
	doctor's order: Indiv						
		t Support Professional Role in					
	Acquiring Needed I	Medications for Individuals:					

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i '		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>00</u>			COMPLETED	
		15G300	B. W	ING		03/13/	2023	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 110 W PIKE ST MARTINSVILLE, IN 46151					
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	BROWDERIC DI ANI OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
W 0368	individual does not possibly resulting in agency's policy for medications from the may notify you that any more refills. The needs a new script the practitioner to contifrom the pharmacy. Agency's policy for new script from the The most important to ensure that you are procedure for acquiry your individual in a 9-3-6(a) 483.460(k)(1) DRUG ADMINIST	the individual does not have is means that the individual o be sent in by the nue to get more medication DSPs need to know their how to address acquiring a practitioner for more refills. thing to remember as a DSP is re familiar with your agency's ring all needed medications for timely manner."						
Bldg. 00		ug administration must						
		gs are administered in						
	Based on record rev sampled clients (clie additional clients (c failed to ensure phy were followed. Findings include: The facility's Bureau Services (BDDS) re 2/28/23 at 12:30 PM following: A BDDS report data	ne physician's orders. Fiew and interview for 3 of 3 ents A, B and C) plus 3 lients D, E and H), the facility sician's orders for medications The of Developmental Disabilities eports were reviewed on The review indicated the Fied 10/2/22 at 8:00 AM 1/2022 it was brought to	W	0368	- Nurse will complete a medication review in the home ensure that all medications are present and are following Physicians Orders - Program Supervisor wi trained on ensuring all medications are present and to notify nursing and manageme any issues with medications or Nurse and Program Supervisor will ensure that all medication refills are correct, ordered in a timely manner, and are given to clients correctly - All staff will be trained or	e II be o nt if ccur	04/28/2023	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	î í	ILDING	instruction 00	(X3) DATE : COMPL 03/13/	ETED
	PROVIDER OR SUPPLIER		•	110 W F	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
1.40	(previous) Program attention that [clien the following medic 10 MG (milligrams on 10-09-2022), do tab (last administere (stomach) 145 MG 10-09-2022 and 10-intestines) 550 MG 10-05-2022). Pharm orders to [Primary (client E's] PCP, last 10-10-2022 via fax. [PCP's] office and solist of needed medic that they have been 72 hours for them to pharmacy. [Client Effects for not being medications. Plan to Resolve: [Primary (Client E's) PCP) to follow up with [Find Forders being sent to administered the formod) 25 mg tablet 10/01/2022), and mg (last given on 10/6/2 request orders to [client Ergent Stated they have sent again on went to [PCP's] office stated they have take up to 72 hours	Director (PPD) [PPD's] It E] had not been administered cations: Cetirizine (for allergies) It ab (tablet) (last administered cusate (stool softener) 240 MG ed on 10-07-2022), Linzess cap (missed dosages ed on 10-2022), Xifaxan (antibiotic for tab (last administered on nacy has sent refill request Care Provider (PCP)] who is set request was sent on [Program Director] went to expoke with office staff and left a cation refills. PCP office stated busy and that it would take to send the refill order to the E] isn't showing any adverse gradministered the listed program Director] will continue PCP's] office daily about refill			medication administration - Program Supervisor wi monitor at least three times perweek during home visits - Program Director will monitor and address any issue the home at least one time perweek during Site Supervisory - Nurse will monitor at least wice weekly during home visit Persons Responsible: Area Director, Program Director, Program Director, Program Supervisor, Nurse	es in visits	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(2) MULTIPLE CO A. BUILDING B. WING	nstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 03/13/2023		
	NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC		STREET ADDRESS, CITY, STATE, ZIP COD 110 W PIKE ST MARTINSVILLE, IN 46151				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF I (EACH DEFICIENCY MUST BE PRE REGULATORY OR LSC IDENTIFYIN	CEDED BY FULL IG INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
	any adverse effects due to the missed medications. [PCP's] nurse called a DSP [Staff #2]. The nurse, [Nurse], would do her best to get the order se [pharmacy] by the end of the day. A [Nurse] stated the Aripiprazole is not by [PCP]. The MAR (medication and record) states Aripiprazole is present [Psychiatric Mental Health Nurse Performancy] in [City, State]. [Program spoke with a call center representate [client C] is not in the system. Plan [Program Director] will continue to [PCP's] office daily regarding refill sent to [Pharmacy]. [Program Director] is implementing a nightly count of all prescribed daily and Pfermedications for each client, which is when the quantity is low." A BDDS report dated 11/11/22 at 8 indicated, "On 11/12/2022 staff was medication audit at [client D's] hon discovered that on 11/11/2022, [clied given his evening medication consist Trospium Chloride (for overactive The program nurse was notified as discovered. The program nurse inst monitor [client D] for signs of adverse of the missed evening medication and noted up to the time of this report. Since we will continue to monitor [client D] for heafety. Plan to Resolve: The Mentor staff a continue to monitor [client D] for heafety. The program nurse will commedication observation and training medication observation and training med	and spoke with a stated she ent to Additionally, of prescribed diministration ribed by tractitioner in Director ive who stated to Resolve: a follow up with requests being eter] will regarding the ally, [Program medication RN (as needed) will alert staff it ent D] was not sting of bladder) 20 mg. soon as it was ructed staff to erse side effects and none were staff and nurse for health and upsete a					

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 15G300	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 03/13/2023			
	NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC		STREET ADDRESS, CITY, STATE, ZIP COD 110 W PIKE ST MARTINSVILLE, IN 46151				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	indicated, "On 11/15/22, [PD] was informed [client B] is out of the following medication; Guanfacine HCL (for anxiety) 20mg. This medication is to be taken 1 x (time) daily per [PCP]. [Pharmacy], group home staff, and [PD] have called [PCP] office requesting the medication be refilled. Plan to Resolve: [PD] will continue to reach out to [PCP's] office until the medication is refilled and brought to the group home." A BDDS report dated 11/15/22 at 7:52 PM indicated, "On 11/15/22, [PD] was informed [client C] is out of the following medication: Aripiprazole (antipsychotic) 20mg, Desvenlafaxine ER (antidepressant) 50 mg, Lamotrigine (mood stabilizer) 25 mg. This medication is to be taken 1 x daily per [PCP]. [Pharmacy], group home staff, and [PD] have called [PCP's] office requesting the medication be refilled. Plan to Resolve: [PD] will continue to reach out to [PCP's] office until the medication is refilled and brought to the group home." A BDDS report dated 11/15/22 at 7:52 PM indicated, "On 11/15/22, [PD] was informed [client H] is out of the following medication: Vitamin B 12 (supplement) 1,000 meg (micrograms). This medication is to be taken 1 x daily per [PCP]. [Pharmacy], group home staff, and [PD] have called [PCP's] office requesting the medication be refilled. Plan to Resolve: [PD] will continue to reach out to [PCP's] office until the medication is refilled and brought to the group home." A BDDS report dated 11/27/2022 staff was conducting a medication audit, and it discovered that on 11/27/2022 several individuals did not receive their						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G300		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 03/13/2023						
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 110 W PIKE ST MARTINSVILLE, IN 46151					
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	(X5) E COMPLETION			
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	DATE			
	-	t D] was not given his evening						
	medication consisti	-						
		ng. [Client C] was not given igh cholesterol) 5 mg, [client						
	· ·	s Invega (antipsychotic) 4.5						
	-	ras not given Clozapine						
		mg, Linzess (for abdominal						
		and Xifaxan (antibiotic for the						
	intestines). The pro	gram nurse was notified as						
		vered. The program nurse						
		nonitor all individuals for signs						
		cts of the missed evening						
		e were noted up to the time of						
	-	d nurse will continue to						
	monitor for health and safety. Plan to Resolve: The Mentor staff and nurse will							
		all for health and safety. The						
		complete a medication						
	observation and tra							
	-	ed 2/7/23 at 8:00 AM indicated,						
		ile Program Director was t of the Medical Administration						
		it was discovered that [client						
		ollowing medication						
		ood) 25 MG Tablet. According						
	- '	C] had not been administered						
	-	rom the 1st through the 7th of						
] has an appointment						
	scheduled with his Psych on February 22nd to							
	_	the pharmacy. [Client C] has						
	not experienced any adverse effects from not							
	being administered medications. Staff will check							
		ensure scripts were received						
		tigation has been initiated to						
	determine the cause	of the inequeation effors.						
	A BDDS report dat	ed 2/7/23 at 8:00 AM indicated,						
	•	ile Program Director was						
		t of the Medical Administration						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G300		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 03/13/2023			ETED			
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP COD 110 W PIKE ST MARTINSVILLE, IN 46151					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
	E] was out of the for CAL 240 MG Soft Levocarnitine 330 M Tamsulosin HCL 0. prostate) and Xifaxa for the intestines). A E] had not been adrifted from the 1st through E] saw his [PCP] on medication refills for [Client E] has not e from not being adm Plan to Resolve: State to ensure scripts we investigation has because of the medicate	MG Tablet (supplement), 4 MG Capsule (for enlarged an 550 MG Tablet (antibiotic According to the record [client ministered these medications in the 7th of February. [Client in 02/07/2023 and they sent in or the above medications. Apperienced any adverse effects inistered medications. Aff will check with [Pharmacy] are received and filled. An initiated to determine the tion errors." Accility's BDDS reports B, C, D, E and H did not ations as prescribed by the ewed on 3/1/23 at 7:15 AM. (DSPs) order the meds, most they are not here when we are are all the supervisor." View (CI) was conducted on and "we call the doctor's office we call to let management know ble." The CI went on to say "I we don't have the tools we						

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

PRINTED: 05/04/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G300		(X2) MULTIPLE A. BUILDING B. WING	00	COM	e survey pleted 3/2023	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC		110 V	ET ADDRESS, CITY, STATE, ZIP CO N PIKE ST TINSVILLE, IN 46151	DD		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	RECTION OULD BE PPROPRIATE	(X5) COMPLETION DATE
	quality department we are re-training a The AD stated the c administered as pre					
	interviewed on 3/7/ "all medications sho clients name and m "staff should be che removing them." The document injection MAR." The RN ind B trained. The RN should always make are in the home before	tered Nurse (RN) was 23 at 11:00 AM. The RN stated build have a label with the edication information" and tecking for expired meds and the RN stated staff should sites by "noting it on the ticated all staff are Core A and stated "staff in the home the sure the clients medications tore they run out." The RN tould have had severe issues"				
	when not receiving The RN stated clien	their prescribed medications. tts' medications should always e physician's orders "should				
	(DSP) Training data 3/7/2023 at 9:00 A following, "Medical administering medication as a rest of medication administerion administerion administerion administerion administerion administerion administerion administerior administration administ	t Support Professional Role in Medications for Individuals: ortant to ensure that your run out of medications n a missed dose. Follow your				

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l l		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		15G300	B. WING 03/13/2023				2023
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC		STREET ADDRESS, CITY, STATE, ZIP COD 110 W PIKE ST MARTINSVILLE, IN 46151					
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	any more refills. The needs a new script to practitioner to continuous from the pharmacy, agency's policy for new script from the The most important to ensure that you are	DSPs need to know their how to address acquiring a practitioner for more refills. thing to remember as a DSP is re familiar with your agency's ring all needed medications for					
W 9999							
Bldg. 00	(c) The residential pits employment prace person would be emperson would be empounded by the provider shall obtain motor vehicles reconcern authorized in IC 5-2 P.L.2-2003, Section IC 10-13-3-27.], and verification of emplements with this compliance with this	Provider shall demonstrate that etices assure that no staff aployed where there is: (3) he substantially related to a on or any violent crime. The n, as a minimum, a bureau of rd, a criminal history check as 2-5-5 [IC 5-2-5 was repealed by a 102, effective July 1, 2003. See d three (3) references. Mere oyment dates by previous constitute a reference in s section.	employee files being current - Area Director and Program Directors will be trained on ensuring employee files are up to date when an Office Coordinator is not present - An audit of employee files tory check as as repealed by aly 1, 2003. See nees. Mere previous rence in employee files being current - Area Director and Program Directors will be trained on ensuring employee files are up to date when an Office Coordinator is not present - An audit of employee files will be conducted to ensure that all items are current - Once an Office Coordinator is hired, a tracking sheet will be put into place to track all employees files to monitor any expirations that can be addressed in a timely manner		04/28/2023		
	sampled staff (staff	riew and interview for 3 of 3 #1, #2 and #3), the facility f #1 and #3 had a valid			Persons Responsible: Area Director, Program Director, Program Supervisor		

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PRINTED: 05/04/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/S		(X2) MULTIPLE (A. BUILDING B. WING	construction 00	COMP	ESURVEY LETED 8/2023	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC		110 V	T ADDRESS, CITY, STATE, ZIP CO V PIKE ST FINSVILLE, IN 46151	D		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	#3 had 3 references	failed to ensure staff #2 and on file.				
	review indicated the Staff #1's file had a expired 6/11/2018. Staff #2's file had n Staff #3's file had a expired on 4/8/2022 references present.	copy of a driver's license that o references present. copy of a driver's license that 2. Staff #3's file had no				
	was interviewed. The driving records show then annually to ensually to ensually to ensually to ensually to ensually the annually to ensually the for reporting issues being expired or sustaff was hired. The care of it (reference are supposed to list recruiters to call, the one, we have a coup The AD indicated the coordinator to assist The AD stated, "it is to print out the reference that an office coordinate to coordinate the reference of the Regional Direct The Regional Direct Coordinate of the Regional Coordi	AM, the Area Supervisor (AD) he AD indicated the staffs' ald be checked upon hire and sure they remain valid. The at the responsibility of the staff with their licenses such as spended. The AD indicated the duct motor vehicle checks after AD stated, "recruiters take as)." The AD stated employees 3 to 5 references for the at way if we can't get a hold of ole of back-ups if they list 5." here has been no office at with the new hire paperwork, as the office coordinator's job rences emailed by the in their file and we haven't inator for over 6 months."				
		. The RD indicated the facility ng staff Bureau of Motor reference checks.				
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/04/2023 FORM APPROVED OMB NO. 0938-039

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 03/13/2023	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP COD 110 W PIKE ST MARTINSVILLE, IN 46151				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NTE.	(X5) COMPLETION DATE
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