STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED					
		15G300	B. WI	NG		10/05/	2021
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY 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)	λΤΕ	(X5) COMPLETION DATE
W 0000							
Bldg. 00	recertification and visit included a Co control survey. Survey Dates: Sept 4 and 5, 2021 Facility Number: 0 Provider Number: AIM Number: 100 These deficiencies accordance with 46	15G300 249100 also reflect state findings in 50 IAC 9.	WO	0000			
W 0102 Bldg. 00	#15068 on 10/14/2 483.410 GOVERNING BC The facility must of governing body a requirements are Based on observation interview for 7 of 7 home (#1, #2, #3, #failed to meet the Coverning Body. If failed to ensure the previous recertification correction was contreatment, document the clients' goals do non-compliance at treatment, client #4 client #5 did not paremained in good remained in good remai	DDY AND MANAGEMENT ensure that specific nd management met. on, record review and clients living in the group 44, #5, #6 and #7), the facility Condition of Participation: The facility's governing body implementation of the ation survey's plan of ducted in regard to active inting the implementation of	WO	102	The QIDP will be retrained to ensure staff implement trainin objectives as written and document skill data from the completed training objectives. staff will be trained on documenting the implementat of training objectives as writte The Program Supervisor and QIDP will review tracking of training objectives at least we to ensure documentation is be completed. Corrective action to be completed with staff if documentation is not completed.	All ion n. ekly eing will	11/04/2021

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

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	ETED
		15G300	B. WI			10/05/	
						10,00,	
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
				_	PIKE ST		
TRANSIT	TRANSITIONAL SERVICES SUB LLC			MARTINSVILLE, IN 46151			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		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
	Disabilities Profess	ional (QIDP) integrated,			as required.		
	coordinated and mo	nitored the clients' program			Client #4 will be reimbursed for	or	
	plans, staff received	l competency based training			the hair cut he paid for with hi	S	
	in regard to client #	4's order for Ferrous sulfate			own money. Client #5 will be		
	(iron supplement) to	be administered with orange			reimbursed for the glasses he		
	juice and client #4's	diet orders, staff			purchased. Staff will be retra	ined	
	implemented the cli	ients' program plans as			on what items Indiana MENT(OR is	
	written, staff docum	nented the implementation of			responsible to pay for to supp	ort	
	the clients' goals an	d training objectives, and the			individuals in the home. Staff	will	
	clients served thems	selves, poured their drinks			also be trained to reach out to	а	
	and participated in I	breakfast preparation.			supervisor before making a		
		• •			purchase that they are unsure	of.	
	Findings include:				A bid for the home repairs was		
					approved in July 2021. The		
	Please refer to V	V104. For 7 of 7 clients			repairs were scheduled to be		
	l '	home (#1, #2, #3, #4, #5, #6			completed the week of Octobe	er	
		's governing body failed to		11th and were started that week			
		lirection over the facility by			as scheduled. The upstairs flo	ors	
) the implementation of the			of the home have been repair		
	_	tion survey's plan of			as well as the flooring on the		
	1 ~	lucted in regard to active			stairs. The holes in the walls a	and	
		menting the implementation			cracks in the plaster have all t		
	of the clients' goals				repaired, sanded and painted		
	_	a condition level for active			well. Any additional		
	_	#4 did not pay for his			maintenance/repairs will be		
		did not pay for his glasses			completed timely to keep the		
	· ·	mained in good repair.			home in good repair.		
		manie in good repuir			Supervisory staff will complete	÷	
	2) Please refer to V	V195. For 7 of 7 clients			three observations per week f		
	l '	home (#1, #2, #3, #4, #5, #6			one month, two observations		
		's governing body failed to			week for one month and then		
		of Participation: Active			weekly ongoing to observe the	9	
		. The facility's governing			home is in good repair and wil		
		re the outside services met			any concerns so maintenance		
		#3, the Qualified Intellectual			can be completed timely.		
		ional (QIDP) integrated,			Observation will also include	meal	
		onitored the clients' program			times to ensure active treatme		
		d competency based training			and that diet plans are being		
	1 ~	4's order for Ferrous sulfate			followed. In addition, medica	tion	
	1 -	be administered with orange			observations will be done to		
	l (mon subbiciliciii) ii	o oc administered with orange	1		Chaci valiona will be done to		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G300	(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 10/05/2021
TRANSIT	ROVIDER OR SUPPLIER	SUB LLC	110 W I	ADDRESS, CITY, STATE, ZIP CODE PIKE ST NSVILLE, IN 46151	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES 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
	written, staff docum the clients' goals and clients served thems	diet orders, staff ents' program plans as mented the implementation of d training objectives, and the selves, poured their drinks oreakfast preparation.		ensure all medication administration protocols are be followed. QIDP will retrain staff on the n for active treatment and follow program plans. QIDP will obsiduring weekly visits to ensure active treatment is occurring. QIDP will be retrained to compromonthly contact with outside service providers. QIDP will h monthly contact (either face to face or electronically) with outside service providers to ensure issure addressed timely. Nurse will work with the pharm to change the delivery of the medications from the home to office. The Nurse and/or QIDF will be responsible for reviewing the medications against the M to ensure clear instructions are given to the home staff regard medication administration and ensure if changes are made to medications, the appropriate if are available to administer the medications as ordered. Responsible Parties: Area Director, QIDP (Program Director), Nurse	eed ring erve blete ave side sues nacy the cong AR ee ing to otems
W 0104 Bldg. 00	policy, budget, and	DY dy must exercise general d operating direction over			
	review for 7 of 7 cli	on, interview and record ents living in the group home #6 and #7), the facility's	W 0104	The QIDP will be retrained to ensure staff implement training objectives as written and	11/04/2021

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í		ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	
		15G300	B. W	ING		10/05/	/2021
NAME OF F	ADOLUDED OD GUDDU ED		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF F	PROVIDER OR SUPPLIER	C .		110 W I	PIKE ST		
TRANSIT	TIONAL SERVICES	SUB LLC		MARTI	NSVILLE, IN 46151		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		\TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	112	DATE
	governing body fail	led to exercise operating			document skill data from the		
	direction over the fa	acility by failing to ensure: A)			completed training objectives	. All	
	the implementation	of the previous			staff will be trained on		
	recertification surve	ey's plan of correction was			documenting the implementat	ion	
	conducted in regard	I to active treatment and			of training objectives as writte	n.	
	documenting the im	plementation of the clients'			The Program Supervisor and		
	goals due to a histor	ry of non-compliance at a			QIDP will review tracking of		
	condition level for a	active treatment, B) client #4			training objectives at least we		
	did not pay for his h	naircut, C) client #5 did not			to ensure documentation is be	eing	
	pay for his glasses a	and D) the home remained in			completed. Corrective action	will	
	good repair.				be completed with staff if		
					documentation is not complet	ed	
	Findings include:				as required.		
					Client #4 will be reimbursed for		
		ed to implement its 9/25/20			the hair cut he paid for with hi		
		to address issues with active			own money. Client #5 will be		
		ocumentation of clients #1,	reimbursed for the glasses he				
	-	nd training objectives. The	purchased. Staff will be retrained				
		ated the following which			on what items Indiana MENT		
		of compliance: "The			responsible to pay for to supp		
		QIDP/Qualified Intellectual			individuals in the home. Staff		
		ional) will be trained on the			also be trained to reach out to	а	
		g, coordinating and monitoring			supervisor before making a		
		ast annually for all individuals			purchase that they are unsure		
	in the home, to com	-			A bid for the home repairs wa	S	
		uding assessing vocational			approved in July 2021. The		
		lly and to update Active			repairs were scheduled to be		
		es when program changes			completed the week of Octob		
		Is in the home. The new Area			11th and were started that we		
		with the Program Director			as scheduled. The upstairs flo		
		review upcoming/and			of the home have been repair	ea	
		plans to ensure timely			as well as the flooring on the	and	
	_	t all required documentation			stairs. The holes in the walls a		
	_	w. Staff in the home were O on ensuring the completion			cracks in the plaster have all		
					repaired, sanded and painted	аъ	
	-	kill data for all individuals as			well. Any additional maintenance/repairs will be		
		eloped plan. The Program Il generate monthly reviews			completed timely to keep the		
		res and complete corrective			home in good repair.		
		e for any discrepancies found			Supervisory staff will complete	2	
	action as applicable	Tot any discrepancies found			Supervisory stair will complete	-	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING OO			(X3) DATE		
AND PLAN	OF CORRECTION		B. WI		00	COMPL	
		15G300	B. W			10/05/	2021
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	-	
				_	PIKE ST		
TRANSIT	TIONAL SERVICES	SUB LLC		MARTIN	NSVILLE, IN 46151		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		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' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	in which staff failed	to complete documentation.			three observations per week for	or	
	Staff in the home w	ill be retrained on the training			one month, two observations p	per	
	goals of the individu	uals and to implement those			week for one month and then		
	goals as written. If	changes are needed for these			weekly ongoing to observe the)	
		will also be completed.			home is in good repair and wil	l	
		ations will be completed at			any concerns so maintenance		
		different shifts to monitor			can be completed timely.		
	-	implemented as written and			Observation will also include		
	-	aff when discrepancies are			times to ensure active treatme	nt	
		he home will be retrained to			and that diet plans are being		
	-	n drills as scheduled. The			followed. In addition,		
		will be retrained to ensure			medication observation will be		
	that all evacuations	-			done to ensure all medication		
	according to the sch				administration protocols are be	eing	
	-	times on each shift each			followed.		
		um Director (QIDP) and/or			QIDP will retrain staff on the n		
		eview all drills after			for active treatment and follow		
	-	ensure they are completed			program plans. QIDP will obs	erve	
	•	drill will be completed. The			during weekly visits to ensure		
		r the Office Coordinator will			active treatment is occurring.		
		all completed drills for			QIDP will have monthly contact	ct	
	immediate review	."			(either face to face or		
					electronically) with outside ser		
		PM, the Area Director (AD)			providers to ensure issues are	!	
		ne new people there. Staff			addressed timely.		
	_	ame page." The AD indicated			Nurse will work with the pharm	nacy	
		or (PD) was aware of the			to change the delivery of the		
		e and she retrained the staff			medications from the home to		
		o indicated the PD should have			office. The Nurse and/or QIDI		
		nentation issue monthly as			will be responsible for reviewir	•	
	-	nonthlies and saw the issues.			the medications against the M		
		nink I need to do a retraining			to ensure clear instructions are		
		Clients should have been			given to the home staff regard	ıng	
		ores, clean up, meals and			medication administration.		
	goals. There's not a	-			Staff will be retrained on Clien		
		ing on." The AD indicated			#4's diet and the administratio	11 01	
		go to the group home to show			Ferrous Sulfate by the Nurse.	tha	
		o do and how to document the			The Nurse will retrain staff on		
	_	AD indicated she needed to			diet plans for all individuals in	uie	
	uo ii again. The AL	stated, "there's no proof			home.		

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G300	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/05/2021
	ROVIDER OR SUPPLIER		110 V	T ADDRESS, CITY, STATE, ZIP CODE V PIKE ST TINSVILLE, IN 46151	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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
	goals are being imp documenting the cli their hard work. W training. (Staff) need AD indicated the cli implemented formation B) On 9/27/21 at 3: #4's finances was confollowing: On 8/30/haircut out of his fire \$13.00. Client #4 let total). There was not was reimbursed by the haircut. Client #4's August 2/Register indicated his was no documentated difference between amount documented Client #4 was mission on 9/28/21 at 1:52 indicated the facility #4 for his haircut. The should pay for client was no documentated the facility #4 for his haircut. The should pay for client was mission on 9/28/21 at 3:31 indicated the facility #4 for his haircut. The should pay for client was mission on 9/27/21 at 3:31 indicated he needed by Observations with one on 9/27/21 from the pay for his haircut at 3:31 indicated he needed by Observations with one on 9/27/21 from the pay for his haircut at 3:31 indicated he needed by Observations with one on 9/27/21 from the pay for his haircut at 3:31 indicated he needed by Observations with one on 9/27/21 from the pay for his haircut at 3:31 indicated he needed by Observations with one on 9/27/21 from the pay for his haircut at 3:31 indicated he needed by Observations with one on 9/27/21 from the pay for his haircut at 3:31 indicated he needed by Observations with one on 9/27/21 from the pay for his haircut at 3:31 indicated he needed by Observations with one on 9/27/21 from the pay for his haircut at 3:31 indicated he needed by Observations with one on 9/27/21 from the pay for his haircut at 3:31 indicated he needed by Observations with one on 9/27/21 from the pay for his haircut at 3:31 indicated he needed by Observations with one on 9/27/21 from the pay for his haircut at 3:31 indicated he needed by Observations with the pay for his	lemented. Staff need to be lents' goals. Get credit for e are going to have to do ed to be documenting." The itents' goals should be lly and informally. 249 PM, a review of client conducted and indicated the '21, client #4 paid for a nances. The haircut was eft a \$10.00 tip (\$23.00 to documentation client #4 the facility for paying for his conducted and indicated the '21 paying for his the receipt (\$23.00) and the don the register (\$27.60). Ing \$4.60. PM, the Area Director (AD) by needed to reimburse client the AD indicated the facility at #4's haircut. 249 PM, a review of client conducted and indicated the '21, client #5 paid \$29.00 to his glasses. PM, the AD indicated client for his glasses. The AD it to be reimbursed.		Responsible Parties: Area Director, QIDP (Program Director), Nurse	
	9/28/21 from 6:27 <i>F</i>	AM to 8:17 AM. During the			

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AND PLAN OF CORRECTION AND STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G300		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 10/05/2021		
	PROVIDER OR SUPPLIER TIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION		
	observations, the following environmental issues were noted affecting clients #1, #2, #3, #4, #5, #6 and #7:					
	1) The carpeting on the stairs was discolored, stained, frayed and had debris on it. The carpeting was located on the stairs leading to the second floor and the second floor hallway/landing. 2) One living room wall had a three inch by six					
	inch hole three feet off of the floor. The chair rail in the living room was scuffed and missing a large section of paint.					
	3) The living room couch was scuffed, torn, worn and ripped.					
	4) The living room window blinds were broken. Two windows were missing blinds.					
	5) Outside of client #5's bedroom, there was a 2 foot by 6 inch hole in the wall near the floor.					
	6) Outside of client #5's bedroom, there was a one foot by one foot hole in the wall above a hole in the wall near the floor.					
	7) Outside of client #5's bedroom, there was a 6 inch in circumference hole in the wall 4 feet off the floor.					
	8) At the top of the stairs, there was an unsanded and unpainted repaired hole in the wall.					
	9) In the living room, there was a 3 inch hole in the wall 5 feet off of the wall to the right of client #2's bedroom door.					
	On 9/28/21 at 7:19 AM, client #5 indicated					

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION 15G300		(X2) MUI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE : COMPL 10/05/	ETED	
	ROVIDER OR SUPPLIER			110 W F	DDRESS, CITY, STATE, ZIP CODE PIKE ST ISVILLE, IN 46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	<u> </u>	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
W 0120 Bldg. 00	holes did not get repaired in a timely manner. Client #5 stated the holes "eventually" get repaired. On 9/27/21 at 12:08 PM, the Area Director (AD) stated "next week" a contractor was going to the group home to replace the carpet with vinyl flooring, repair holes in the wall and repaint all the walls. The AD indicated a new couch had been ordered. 9-3-1(a) 483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE		W 01	20	An IDT will be scheduled for C #3 with the outside service provider.	lient	11/04/2021
	client #3. Findings include: On 9/27/21 from 2:0 observation was corservices workshop of Throughout the observation with a was on his cell p #3 did not do work of a collection of the follow at an outside service his cellphone. He s	200 PM to 2:50 PM, an aducted at the outside client #3 attended. Prvation, client #3 was a his cell phone out. Client chone during the visit. Client during the observation. 2 AM, a review of the ports was conducted and ing: On 6/14/21 at 1:18 PM es workshop, client #3 was on lammed his cellphone on the tocked over a chair before			QIDP will have monthly contact (either face to face or electronically) with outside ser providers to ensure issues are addressed timely. Responsible Parties: Area Director, QIDP (Program Director)	vice	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G300	` ′	JILDING	nstruction 00	(X3) DATE COMPL 10/05/	ETED
	PROVIDER OR SUPPLIER			110 W F	NDDRESS, CITY, STATE, ZIP CODE PIKE ST NSVILLE, IN 46151	•	
					10 VIELE, IIV 40 10 1		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFRENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	workshop and out of 6/14/21 Bureau of I Services report indischedule a team me bringing his phone of the property of the services report indischedule a team me bringing his phone of the workshop manager of the workshop manager of the workshop mana apologize for just result of the workshop manager indicated, "Yes, is the a meeting for next where workshop manager the services of the workshop manager needed to convene the services of the workshop manager needed to convene the services of the working spends most of his to or sleeping.	PM, a review of client #3's ed. A 6/21/21 Indiana stes document indicated, vior Specialist] and [Program the IDT (interdisciplinary time of outside services requested the meeting. She terns. Once the meeting taide services workshop in the call" An email from the call					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G300		A. BUILDING 00 B. WING		(X3) DATE SURVEY COMPLETED 10/05/2021	
	PROVIDER OR SUPPLIER FIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
W 0124	The AD indicated the Program Director (PD) should have followed up and come up with a plan to address the workshop manager's concerns. The AD stated the PD should conduct "at least monthly" visits to the outside services workshop. 9-3-1(a) 483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The focility must ensure the rights of all				
Bldg. 00	The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. Based on interview and record review for 1 of 3	W 0124	Area Director will review the	11/04/2021	
	clients in the sample (#2), the facility failed to ensure client #2's guardian was notified of doctor's appointments, the outcome of doctor's appointments, changes in management at the group home, and progress on goals and training objectives.	W 0124	guardian contacts done by the QIDP to ensure relevant communication is occurring. Nurse will initiate contact with guardian of Client #2 on a more basis to ensure medical information is shared.		
	Findings include: On 9/29/21 at 9:46 AM, client #2's guardian indicated she did not receive updates regarding client #2's medical appointments, money, meetings or changes in management. The guardian stated she "hears nothing." The guardian indicated she wanted to know when medical appointments were scheduled and the outcome of the appointments, to be invited to meetings and the status of his training objectives. The guardian indicated she requested the facility take over as client #2's representative payee 6 months ago however she has not received an update regarding the status of the facility taking over.		Documentation will be done of Guardian Contact form. Paperwork has been submitted the Social Security Administration to change the representative payee from guardian of #2 to Indiana Mentor. Intake Service Coordinator is monitoring to ensure the process is successful. Responsible Parties: Area Director, QIDP (Program Director), Nurse	d to tion	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G300		A. BUILDING B. WING	A. BUILDING <u>00</u> COMPLETED				
	PROVIDER OR SUPPLIER FIONAL SERVICES SUB LLC	110 W	STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	On 9/28/21 at 11:51 AM, a review of client #2's record was conducted. Client #2's guardian was contacted three times (in February 2021) from September 2020 to September 2021 based on the documentation of guardian contact. On 9/29/21 at 2:01 PM, the Area Director (AD)						
	indicated the guardian should receive regular communication from the facility regarding client #2's progress and medical appointments. The AD indicated the guardian should receive documentation of client #2's monthly progress reports. The AD stated the "PD (Program Director) should be contacting guardians." The						
	AD indicated there should be documentation of guardian contact throughout the year. The AD indicated she was not aware of the request 6 months ago for the facility to be client #2's representative payee until about 2 months ago when the guardian contacted her about it.						
W 0125	9-3-2(a) 483.420(a)(3)						
Bldg. 00	PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.						
	Based on observation, record review and interview for 3 of 3 clients in the sample (#1, #2 and #3), the facility failed to ensure the clients had the right to due process in regard to restricting the clients' access to their food. Findings include:	W 0125	QIDP retrained staff and Progressive Supervisor on regarding the clarights to have access to food a that the use of the basement storage is only for overflow an not to limit available food. QIDP will monitor during week	lient and d			

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G300	(X2) MULTIPLE C A. BUILDING B. WING	OO OO	(X3) DATE SURVEY COMPLETED 10/05/2021
	ROVIDER OR SUPPLIER		110 W	FADDRESS, CITY, STATE, ZIP CODE I PIKE ST FINSVILLE, IN 46151	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES 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)	DATE
	On 9/27/21 from 3:3 observation was con Throughout the obsewas locked. There containers stored in them. The food incomplete them. The food incomplete them in the food incomplete them in the kit with the locked basement the clients in the kit with the locked basement the clients in the kit with the clients in the kit with the clients from eath indicated the food in available to the client locking of the food. 1) On 9/28/21 at 11 with the restriction of lockeep him from having the food. 2) On 9/28/21 at 11 with the food. 2) On 9/28/21 at 11 with the food. Client with the food. Client with the food in the food. Client with the food in the food.	and aducted at the group home. By PM to 5:56 PM, an aducted at the group home. By PM to basement door were several plastic the basement with food in a luded pancake mix, cereal, treats, crackers, applesauce, to be a bars, tuna, chips, and to be of the items located in the twere available, unlocked, to be chen. This affected clients PM, the Program Supervisor and body was locked up to keep and the basement was not be an the clients' plans. By PM, a review of client ducted. Client #1's 11/24/20 foort Plan (ISP) did not include be a basement door to be a seement door to be a seement door to be a seement door. Behavior Support Plan (BSP) the setriction of locking the seep him from having access Solution of locking the seep him from having access BSP did not include the		visits to ensure an adequate of supply exists for all clients to access. Responsible Party: QIDP (Program Director)	
	restriction of lockin	g the basement door to keep			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	00	(X3) DATE SURVEY COMPLETED	
		15G300	B. WING		10/05/2021
	ROVIDER OR SUPPLIER		110 V	ET ADDRESS, CITY, STATE, ZIP CODE N PIKE ST TINSVILLE, IN 46151	
(X4) ID PREFIX TAG	(EACH DEFICIENCE REGULATORY OR him from having account of the second of	:21 PM, a review of client	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	ISP did not include basement door to ke to the food. Client #3's 12/19/20	ducted. Client #3's 7/24/20 the restriction of locking the ep him from having access BSP did not include the g the basement door to keep eess to the food.			
	(AD) indicated the f should be the overfl should be food of ea kitchen to the clients	AM, the Area Director food locked in the basement ow. The AD indicated there such kind available in the strict the clients' access to the me.			
W 0140 Bldg. 00	system that assure accounting of clier entrusted to the fa Based on observation review for 6 of 7 cli (#1, #2, #4, #5, #6 a keep a full and compositents' finances. Findings include: On 9/27/21 at 3:49 I	stablish and maintain a es a full and complete	W 0140	A full audit of the finances for each person will be done by the QIDP and/or Area Director. Any expenditures that are not supported with receipts or othe documentation will be reimbur to the individual. The QIDP and the Program Supervisor will be retrained or Individual Finance Process and Policy. The QIDP will verify with Area	er sed the

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPLETED	
		15G300	B. WI	NG		10/05/2021	
				CTD FFT A	ADDRESS OF A STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIE	₹			ADDRESS, CITY, STATE, ZIP CODE		
TD 4 N 0 IT		0.15.1.0			PIKE ST		
TRANSII	IONAL SERVICES	SUBLLC		MARIII	NSVILLE, IN 46151		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X	(5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPL	ETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DAT	Œ
	1) Client #1's June	2021 Bank Card Transaction			Director Monthly that the indiv	dual	
	Register indicated a	an ending balance of \$88.11.			finances have been reviewed	and	
	The July 2021 Bank Card Transaction Register				reconciled monthly on the We	ekly	
	indicated a starting balance of \$50.75. There was				Review Form.		
	no documentation accounting for the missing				Effective 10.1.2021 the Area		
	\$37.36.				Director is required to do a		
					minimum of 2 financial audits	oer	
	Client #1's cash on hand for September 2021				month and report during the		
	indicated a balance of \$0.95. When the Program				monthly Area Director meeting	I	
	Supervisor (PS) con	unted client #1's money, he			The Area Director will include		
	had \$0.94.				additional audit of one individu	al's	
					finances from the Martinsville		
	2) Client #2's March 2021 Bank Card				Group home.		
	_	er indicated an ending balance			Client #4 will be reimbursed fo		
	of \$50.00. The Apr				the purchase of a haircut. Clie	I	
	_	er indicated a starting balance			#5 will be reimbursed for the g	lass	
		vas no documentation			frames that he purchased.		
	accounting for the	missing \$3.62.			Staff and Program Supervisor		
					were retrained by the QIDP		
	_	21 Bank Card Transaction			regarding purchases that would	I	
		a balance of \$46.38. On			be the responsibility of the fac	· .	
		s deposited into the account.			versus the person served sinc	€	
		dicated as \$92.56. There was			they are participating in an		
		accounting for the missing			ICF-IDD setting.		
	\$3.82.				Staff will be retrained on	tom.	
	Cliant #2!1-	hand for Contamber 2021			maintaining the personal inver sheets for all individuals as ite	·	
		hand for September 2021 of \$0.43. When the Program				115	
		of \$0.43. When the Program unted client #2's money, he			are purchased or discarded. Responsible Parties: Area		
	had \$0.54.	unted chent #2 s money, he			Director, QIDP (Program		
	nau 50.54.				Director)		
	Client #2's May 20	21 Bank Card Transaction			Director,		
		an ending balance of \$142.56.					
	•	sters to review for June, July,					
	_	aber 2021. When the PS					
		heck the balance, the balance					
		was no documentation					
	accounting for the						
	201 310 1	B +					
	3) Client #4's Apri	1 2021 Bank Card Transaction					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO UILDING	NSTRUCTION 00	COMPL		
		15G300	B. W	ING		10/05/	/2021
	ROVIDER OR SUPPLIER			110 W F	ADDRESS, CITY, STATE, ZIP CODE PIKE ST NSVILLE, IN 46151	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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)	ATE	(X5) COMPLETION DATE
	Register indicated h \$51.58. On 4/15/21 the account. The ba	he had a starting balance of 1, \$50.00 was deposited into halance was \$79.31. There was accounting for the missing					
	Register for June 20 May 2021 was \$129 July 2021 was \$50.9	ove a Bank Card Transaction 121. The ending balance in 123. The starting balance in 124. There was no 125. There was no 126. There was no 127. There was no 128. There was no 129. There was no					
	finances was condu following: On 8/30/ haircut out of his fin \$13.00. Client #4 lo total). There was no	PM, a review of client #4's cted and indicated the /21, client #4 paid for a nances. The haircut was eft a \$10.00 tip (\$23.00 o documentation client #4 the facility for paying for his					
	Register indicated h was no documentate difference between	2021 Bank Card Transaction his haircut was \$27.60. There ion accounting for the the receipt (\$23.00) and the d on the register (\$27.60). hg \$4.60.					
	Register indicated h	rch 2021 Cash Transaction are withdrew cash in the with no documentation of this money on:					
	On 10/1/21 at 10:30) AM, a review of client #5's					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G300	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 10/05/2021
	ROVIDER OR SUPPLIER		110 W I	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151	E
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE COMPLETION
	_	eted and indicated he had bed for in receipts in March			
	Register indicated h following amounts what client #5 spent -4/4/21: \$90.00 -4/10/21: \$16.42 -4/14/21: \$500.00 -4/17/21: \$5.00 -4/24/21: \$170.47 On 10/1/21 at 10:30 receipts was conductive.	il 2021 Cash Transaction e withdrew cash in the with no documentation of this money on: O AM, a review of client #5's eted and indicated he had I for in receipts in April			
	Register indicated he following amounts what client #5 spent -5/1/21: \$15.00 -5/1/21: \$70.00 for store -5/1/21: \$80.00 for gas station -5/19/21: \$10.00 for spend down -5/21/21: \$10.00 for station -5/29/21: \$20.00 for station -5/29/21: \$120.00 for	cash on hand, outing and or cash on hand, outing and or cash on hand, outing and or cash on hand and gas or cash on hand and gas or cash on hand and outing			
		AM, a review of client #5's sted and indicated he had			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G300	l í	ILDING	nstruction 00	(X3) DATE COMPL 10/05/	ETED
	PROVIDER OR SUPPLIER		_	110 W F	ADDRESS, CITY, STATE, ZIP CODE PIKE ST NSVILLE, IN 46151	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) for in receipts in May 2021.		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
	4d) Client #5's June Register indicated h following amounts what client #5 spent -6/5/21: \$204.07 on -6/12/21: \$200.00 o station -6/18/21: \$100.00 o and outing -6/26/21: \$300.00 o On 10/1/21 at 10:30 receipts was conduct \$305.45 unaccounte 2021. 4e) Client #5's July Register indicated h following amounts what client #5 spent -7/3/21: \$40.00 on -7/10/21: \$40.00 on -7/11/21: \$306.89 o con -7/17/21: \$139.41 o cash on hand -7/24/21: \$171.11 o -7/31/21: \$159.05 o On 10/1/21 at 10:30 receipts was conduct \$217.31 unaccounte 2021.	e 2021 Cash Transaction e withdrew cash in the with no documentation of this money on: gas station and outing n cash on hand, outing, gas n cash on hand and outing AAM, a review of client #5's sted and indicated he had d for in receipts in June 2021 Cash Transaction e withdrew cash in the with no documentation of this money on: outing and cash on hand outing and cash on hand n cash on hand and comic n gas station, outing and n outing					
	what client #5 spent						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G300		(X2) MULTIPLE (A. BUILDING B. WING	OO	(X3) DATE SURVEY COMPLETED 10/05/2021	
	ROVIDER OR SUPPLIER		110 W	r address, city, state, zip code / PIKE ST TNSVILLE, IN 46151	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	COMPLETION
	-8/8/21: \$198.00 On 10/1/21 at 10:30 receipts was conducted \$78.01 unaccounted 2021. The grand total of fron the documentation \$1154.27. On 9/30/21 at 3:40 indicated the facility and the items client AD indicated she with client #5 could safe his own. The AD in assess this. The AD client #5 was at risk stated, "he would te for money." 5) Client #6's June Register indicated a were no registers for 2021 to review. WI #6's money, he had documentation accordifference. Client #6's March 2 Register indicated he \$50.00. The April 2 \$35.00. There was for the missing \$15.00. Client #6's April 20 Register indicated he \$50.00. The missing \$15.00. Client #6's April 20 Register indicated he \$50.00. The missing \$15.00. Client #6's April 20 Register indicated he safe the safe that the	DAM, a review of client #5's eted and indicated he had a for in receipts in August and sunaccounted for based on and receipts reviewed: PM, the Area Director (AD) y needed to document where #5 spent his money on. The ras not sure how much money ly carry and account for on adicated the facility did not D indicated she did not believe a for exploitation. The AD ell me if someone asked him 2021 Cash Transaction abalance of \$3.50. There for July, August and September then the PS counted client \$11.42. There was no bounting for the \$7.92 021 Bank Card Transaction are had an ending balance of 2021 starting balance was no documentation accounting			
	There was no docur	mentation accounting for the			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G300	(X2) MUL A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE : COMPL 10/05/	ETED
	PROVIDER OR SUPPLIER			110 W P	DDRESS, CITY, STATE, ZIP CODE PIKE ST ISVILLE, IN 46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Client #6's May 202 Register indicated h \$50.00. There was 2021. The starting h \$62.62. There was for the \$12.62 differ 6) Client #7's July 2 Register indicated a Client #7 did not ha was zero. There was accounting for client Client #7's April 20 Register indicated h \$147.23. The May \$122.79. There was for client #7's missin Client #7's missin Client #7's missin Client #7's may 202 Register indicated h \$63.28. There was The July 2021 startin was no documentatin missing \$63.15. On 9/27/21 at 4:22.2 (PS) indicated the c accounted for to the even though "there he received text aler accounts so he knew PS indicated the ale of when and where stated some of the c iffy."	2021 Cash Transaction In ending balance of \$60.00. In ending balance of \$60.00. In each on hand. His balance Is no documentation It #7's missing \$60.00. In Each Card Transaction It had an ending balance of 2021 starting balance was Is no documentation account					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G300		ľ í	ILDING	nstruction <u>00</u>	(X3) DATE : COMPL 10/05/	ETED	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151				
(X4) ID PREFIX TAG	SUMMARY ST	FATEMENT OF DEFICIENCIES 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 APPROPRIAT DEFICIENCY)	TE	(X5) COMPLETION DATE
W 0149 Bldg. 00	indicated the clients accounted for to the PM, the AD stated to "fixed back in Marce The AD indicated the finances. On 10/1/21 at 11:34 staff should be accoon the clients' regist "easy to do. Every documented. The AD irector said she "bothere were issues with AD indicated at the #5 needed to be rein lack of documentati his personal finance manage. 9-3-2(a) 483.420(d)(1) STAFF TREATME The facility must dwritten policies and mistreatment, neg	'finances should be penny. On 9/28/21 at 1:52 he clients' finances were h. Needs to be fixed again." he PS needed to be trained on AM, the AD indicated the unting for each transaction ers. The AD stated it was single transaction" should be aD indicated the Program ets it was a mess" when told the clients' finances. The time of the interview, client inbursed \$1154.27 due to the on and missing receipts for sentrusted to the facility to	Wo		Area Director and/or QIDP will		
	additional clients (# implement its polici exploitation by ensu were accounted for use, staff immediate neglect to the admir incident to the Bure Disabilities Services accordance with star corrective action was	4), the facility failed to es and procedures to prevent ring client #4's possessions and in the home for him to ly reported an allegation of aistrator and reported an au of Developmental s (BDDS) within 24 hours, in te law and recommended as implemented following an eloping from an outside	W 0	149	retrain staff on definitions of Abuse, Neglect and Exploitation and reporting requirements. Supervisory staff will complete three observations per week for one month, two observations per week for one month and then weekly ongoing to observe interactions for the prevention ANE and any incidents are reported timely. Responsible Parties: Area	on or oer	11/04/2021

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15G300	B. W	NG		10/05/	2021
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			110 W F	PIKE ST		
TRANSIT	TIONAL SERVICES	SUB LLC			NSVILLE, IN 46151		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Findings include:				Director, QIDP (Program Director)		
	1) On 9/27/21 at 3:49 PM, a review of the						
	· ·	s conducted and indicated the					
	following issue:	s conducted and indicated the					
	ionowing issue.						
	-	1 Bank Card Transaction e spent the following:					
	-7/4/21: Ticket \$30.	52					
	-7/15/21: Mall \$434	.00					
	-7/15/21: Clothes \$2	254.81					
	-7/15/21: Clothes \$7	71.66					
	-7/16/21: Stuff/Clot	hes \$133.64					
	-7/17/21: [Name of	store] \$202.14					
	-7/18/21: [Name of	store] \$195.23					
	-7/20/21: [Name of	store] \$62.75					
	-7/24/21: [Name of	store] \$64.17					
	7/15/21 indicated se purchased. When c were reviewed on 9.	clothing purchased on everal items of clothing lient #4's closet and dresser /28/21 during the observation 17 AM, none of the items s was present.					
		personal property inventory include the items purchased.					
		AM, the Area Director (AD) um Director should be					

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	TOF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI		00	COMPL	
		15G300	B. WING	·		10/05/	2021
				STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	Ł		110 W P	PIKE ST		
TRANSIT	TIONAL SERVICES	SUB LLC			ISVILLE, IN 46151		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PR	EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	1	ΓAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE
	checking the clients	s' finances and receipts to					
		rchased were in the home.					
		he was unable to locate the					
	clothing client #4 p	urchased. The AD indicated					
		to look into the purchases and					
	I -	ns client #4 purchased.					
	ay to return the rolling tribute, a partitional						
	2) On 6/21/21 at 6:	00 AM (reported to the					
	administrator on 6/2	24/21), staff #7 arrived to					
	work and found star	ff #12 asleep at the dining					
	room table. The 6/2	25/21 BDDS report indicated,					
	in part, "She reported a second staff came on						
	duty and woke him up. Staff reported she had						
	sent a text message to the QIDP (Qualified						
		ties Professional) and Area					
		, but realized on 6/24/21 the					
	_	nt and reported the incident					
	_	nmediately suspended once the					
		ported An investigation was					
		uality Improvement					
	1 -	llegation could not be					
		on interviews with staff					
	I -	t #6]" This affected clients					
	#1, #2, #3, #4, #5, #	#6 and #/.					
	3) On 7/20/21 at 5:	00 PM (reported to BDDS					
	l '	7 alleged staff #13 asked him					
	•	taff #13 using staff #13's					
		aff was on duty. The 8/4/21					
	1	ated, "Staff informed the					
	_	r that [client #7] recanted his					
		o allegation that staff					
		while on duty. There was no					
		rchased alcohol being brought					
		rogram Supervisor verified					
		n 7/31/21 (the) Program					
		ned of his alleged incident.					
		nterviewed [client #7], staff					
		dual who was on an outing at					
		ged incident. There was no					
		-	1				

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 $GMYL11 \quad \text{Facility ID:} \quad 000819$

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	OF CORRECTION	IDENTIFICATION NUMBER: 15G300	A. BUILDING B. WING	<u>00</u>	COMPLETED 10/05/2021
	PROVIDER OR SUPPLIER		110 W I	ADDRESS, CITY, STATE, ZIP CODE PIKE ST NSVILLE, IN 46151	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	[client #7] spoke to about the alleged incomposition was determed alleged incident and individuals and other 8/19/21 Incident Folics (sic) investigation was determed allegation was determed the staff was termed eff 8/10/21 Mentor Net Internal Investigation evidence to substanticate to substanticate and inappropriate consubstantiated." On 9/27/21 at 12:47 indicated incidents swithin 24 hours. The allegation of neglect have been reported administrator by phosphore to the substantiated the followes at an outside service his cellphone. He shall the substantial end in the	PM, the Area Director should be reported to BDDS are Area Director indicated the at involving client #7 should ammediately to the one. 159 AM, a review of the ports was conducted and aing: On 6/14/21 at 1:18 PM are workshop, client #3 was on ammed his cellphone on the ocked over a chair before itent #3 walked away from the filine of sight of staff. The Developmental Disabilities cated, "I would like to eting about [client #3]			

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Event ID:

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	ENT OF DEFICIENCIES N OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G300	r í	UILDING	onstruction 00	(X3) DATE COMPL 10/05/	ETED
	F PROVIDER OR SUPPLIEF			110 W F	ADDRESS, CITY, STATE, ZIP CODE		
TRANS	SITIONAL SERVICES	SUB LLC		MARTIN	NSVILLE, IN 46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY 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)	TE	(X5) COMPLETION DATE
	"[Guardian], [Behan Director] attended to team) meeting. [Natworkshop manager] didn't state her conditions started [name of our manager] was not on the workshop mana apologize for just refiname of outside secout. Can was resching program Director refindicated, "Yes, is to a meeting for next to documentation the state of the workshop manager needed to convene the manager indicated apable of working spends most of his to or sleeping. On 9/29/21 at 2:01 indicated the have followed up an address the workshop management processes to protect ind Mentor promotes a seeks to protect ind Mentor services the management processo operations, close meeting the state of the protect of the management processo operations, close meeting the processor of the protect of the processor of the proce	-					

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Event ID:

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PRINTED: 11/10/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G300		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 10/05/2021	
	ROVIDER OR SUPPLIER		110 W	ADDRESS, CITY, STATE, ZIP CODE PIKE ST INSVILLE, IN 46151	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES 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 APPROPRIAL DEFICIENCY)	(X5) COMPLETION DATE
W 0153 Bldg. 00	exposed" The Appolicy indicated, in are prohibited by en MENTOR: abuse, n mistreatment of an iof an individual's rights." 9-3-2(a) 483.420(d)(2) STAFF TREATMEThe facility must emistreatment, neg injuries of unknow immediately to the officials in accordatestablished processased on record revincident reports review, #2, #3, #4, #5, #6 are ensure staff immediately to the adminicated to the Bure Disabilities Services accordance with states. Findings include: On 9/27/21 at 11:59 facility's incident reindicated the follow. 1) On 6/21/21 at 6: administrator on 6/2 work and found staff room table. The 6/2 in part, "She report	ENT OF CLIENTS Insure that all allegations of lect or abuse, as well as in source, are reported administrator or to other ance with State law through dures. The word affecting clients #1, and #7, the facility failed to ately reported an allegation ministrator and reported an au of Developmental is (BDDS) within 24 hours, in the law.	W 0153	Area Director and/or QIDP will retrain staff on definitions of Abuse, Neglect and Exploitati and reporting requirements. Supervisory staff will complete three observations per week fone month, two observations week for one month and then weekly ongoing to observe interactions for the prevention ANE. Responsible Parties: Area Director, QIDP (Program Director)	on e for per

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	ULTIPLE CO JILDING	00	(X3) DATE COMPL		
11112 12111	or conumerner.	15G300	B. W		00	10/05/	
		100000				10/00/	2021
NAME OF F	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE		
TRANSIT	TIONAL SERVICES	SUB LLC			NSVILLE, IN 46151		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DDOVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	sent a text message	to the QIDP (Qualified					
		ties Professional) and Area					
		, but realized on 6/24/21 the					
	-	nt and reported the incident					
	-	mediately suspended once the					
	-	oorted An investigation was					
		uality Improvement					
	*	llegation could not be on interviews with staff					
		#6]" This affected clients					
	#1, #2, #3, #4, #5, #	-					
	$\pi_1, \pi_2, \pi_3, \pi_7, \pi_3, \pi_7$	o and π / .					
	2) On 7/30/21 at 5:	00 PM (reported to BDDS					
	· /	7 alleged staff #13 asked him					
	· ·	taff #13 using staff #13's					
	money while the sta	iff was on duty. The 8/4/21					
	BDDS report indica	ted, "Staff informed the					
	Program Supervisor	that [client #7] recanted his					
	story. There was no	allegation that staff					
	consumed alcohol v	while on duty. There was no					
		rchased alcohol was brought					
		rogram Supervisor verified					
		n 7/31/21 (the) Program					
		ned of his alleged incident.					
	_	nterviewed [client #7], staff					
		dual who was on an outing at					
		ged incident. There was no					
		eged incident. On 8/3/21 the Program Supervisor					
		cident again. Staff was					
	_	an investigation on the					
		I to ensure the safety of the					
	_	ers in the home" The					
		llow Up Report indicated, "A					
		vas complete (sic) and the					
		rmined to be substantiated.					
	-	fective 08/17/2021." The					
	8/10/21 Mentor Net	work Report Form for					
	Internal Investigation	on indicated, "There is					
	evidence to substan	tiate that [staff #13] asked					
			<u> </u>				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G300		l í	ILDING	nstruction <u>00</u>	(X3) DATE COMPL 10/05/	ETED	
	ROVIDER OR SUPPLIER			110 W F	NDDRESS, CITY, STATE, ZIP CODE PIKE ST NSVILLE, IN 46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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)	TE	(X5) COMPLETION DATE
W 0157 Bldg. 00	[client #7] did make of inappropriate corsubstantiated." On 9/27/21 at 12:47 indicated incidents within 24 hours. The allegation of neglechave been reported administrator by phosphare of the phosphare of the alleged violation of the alleged viol	PM, the Area Director should be reported to BDDS are Area Director indicated the trinvolving client #7 should immediately to the immediately to the one. ENT OF CLIENTS appropriate must be taken. Friew and interview for 1 of 8 are reports reviewed affecting and incident of client #3 side services workshop. AM, a review of the ports was conducted and ing: On 6/14/21 at 1:18 PM are workshop, client #3 was on a lammed his cellphone on the cocked over a chair before the tient #3 walked away from the fine of sight of staff. The Developmental Disabilities cated, "I would like to etting about [client #3]	W 0	157	An IDT will be scheduled for C #3 with the outside service provider to determine if change are needed for his program pla If changes are made, staff in th home will be trained on the changes. The QIDP will document mont face to face and/or electronic communication with outside service provider. Responsible Parties: Area Director, QIDP (Program Director)	es an. he	11/04/2021

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	OF CORRECTION	IDENTIFICATION NUMBER: 15G300			COMPLETED 10/05/2021	
	ROVIDER OR SUPPLIER		110 W	ADDRESS, CITY, STATE, ZIP CODE PIKE ST INSVILLE, IN 46151		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	REGULATORY OR	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE	
	record was conducted Mentor Meeting No "[Guardian], [Behav Director] attended the team) meeting. [Na workshop manager] didn't state her concustarted [name of out manager] was not on the workshop managapologize for just re [name of outside serout. Can was resched Program Director re indicated, "Yes, is that a meeting for next we documentation the I on 9/27/21 at 2:25 I workshop manager in needed to convene to The manager indicated capable of working a spends most of his thought of the AD indicated the have followed up an address the workshop 9-3-2(a)	PM, a review of client #3's ad. A 6/21/21 Indiana tes document indicated, rior Specialist] and [Program ne IDT (interdisciplinary me of outside services requested the meeting. She terns. Once the meeting side services workshop in the call" An email from the call An email from the ger on 6/29/21 indicated, "I sponding. Our internet at revices workshop] has been edule (sic) Thank you." The sponded on 6/30/21 and there a good time to schedule treek?" There was no DT was rescheduled. PM, the outside services andicated client #3's IDT to discuss his cell phone use. The ted although client #3 was and doing a good job, he time either on his cell phone PM, the Area Director (AD) to aware of an IDT being held. The program Director should do come up with a plan to the program Director should do come up with a plan to the program of the program of the program of the program of the plan to the program of the p				
W 0159	483.430(a) QIDP					
Bldg. 00	be integrated, coo	e treatment program must rdinated and monitored by rual disability professional				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u> COMPLETE		
		15G300	B. WI	NG		10/05/2021
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
					PIKE ST	
TRANSIT	TIONAL SERVICES	SUB LLC		MARTII	NSVILLE, IN 46151	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(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'	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	who-					
	Based on observation	on, record review and	\mathbf{w}_0	159	The QIDP will be retrained to	11/04/2021
		clients in the sample (#1, #2	'' "	10)	ensure staff implement training	
		ed Intellectual Disabilities			objectives as written and	
	Professional (QIDP)				document skill data from the	
		itor the clients' program			completed training objectives.	
	plans.	nor the elicitis program			Area Director will monitor the	
	Pruns.				QIDP's contact with Outside	
	Findings include:				Service Providers no less than	
	rindings include.				monthly.	
	1) Planca rafar to W	/120. For 1 of 1 client (#3)			Area Director will monitor Nurs	
	1 '	le services workshop #1, the			and QIDP's contacts with	
		-				lv.
	1	d to ensure the outside			Guardians no less than month	· I
	services met the nee	eds of client #3.			Area Director will monitor QIDI	S
	0 D1 0 1	1104 F. 1 CO 11			oversight of client rights and	
	1 '	/124. For 1 of 3 clients in			access to food during weekly	
		facility's QIDP failed to			visits no less than monthly.	
	_	nardian was notified of			Area Director will retrain QIDP	
		its, the outcome of doctor's			individual finances and monito	
		ges in management at the			QIDP's completion of individua	
		ogress on goals and training			finance review and reconciliati	
	objectives.				Area Director will review Week	dy
					Checklist and items on the	
	· 1	/125. For 3 of 3 clients in			Weekly Review form to ensure	
		and #3), the facility's QIDP			oversight and action steps are	
	failed to ensure the	clients had the right to due			completed. Area Director and	
	process in regard to	restricting the clients'			QIDP will meet weekly until all	
	access to their food.				POC action steps are complete	ed
					or initiated.	
	l '	7140. For 6 of 7 clients			Responsible Party: Area	
	living in the group h	nome (#1, #2, #4, #5, #6 and			Director	
	#7), the facility's QI	DP failed to keep a full and				
	complete accounting	g of the clients' finances.				
	5) D1	7100 E 1 C4 11'-' 1				
	l '	/189. For 1 of 4 additional				
	` ′′	lity's QIDP failed to ensure				
	_	etency based training in				
	~	order for Ferrous sulfate				
		be administered with orange				
	juice and client #4's	diet orders.				

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AND PLAN O	OF CORRECTION	IDENTIFICATION NUMBER: 15G300	A. BUILDING 00 B. WING		COMPLETED 10/05/2021	
	ROVIDER OR SUPPLIER		110 W I	ADDRESS, CITY, STATE, ZIP CODE PIKE ST NSVILLE, IN 46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
	failed to ensure the continuous, aggressist treatment programs implementation of the sample (#1, #2 a failed to ensure staff program plans as with the sample (#1, #2 a failed to ensure staff implementation of the sample (#1, #2 a failed to ensure staff implementation of the sample (#3), the ensure client #3's coassessment (CFA) wand updated at least 10) Please refer to the sample (#3), the ensure client #3's In (ISP) was revised at 11) Please refer to the sample (#1, #2 a failed to ensure the sample (#1, #2 a failed to e	tive and consistent active including the ne clients' program plans. 249. For 3 of 3 clients in and #3), the facility's QIDP implemented the clients' ritten. 252. For 3 of 3 clients in and #3), the facility's QIDP included the ne clients' goals and training as reviewed for relevancy annually. 259. For 1 of 3 clients in facility's QIDP failed to as reviewed for relevancy annually. 260. For 1 of 3 clients in facility's QIDP failed to dividualized Support Plan least annually. 262. For 3 of 3 clients in and #3), the facility's QIDP specially constituted Rights Committee/HRC) and monitored the clients' plans. 263. For 3 of 3 clients in and #3), the facility's QIDP specially constituted Rights Committee/HRC) and monitored the clients' plans.				

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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 10/05/2021			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES 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 0189 Bldg. 00	ensured written info for the clients' restri the clients' guardian 9-3-3(a) 483.430(e)(1) STAFF TRAINING The facility must p initial and continui employee to perfo effectively, efficier		W 0189	Nurse will retrain Program	11/04/2021
	interview for 1 of 4 facility failed to ens competency based t #4's order for Ferror	additional clients (#4), the	W 0103	Supervisor and staff on review the MAR and following instruct administering medications. Nurse will train Program Supervisor and staff on all die plans in the home. Supervisory staff will complete three observations per week for one month, two observations	ving tions t
	observation was con At 5:07 PM, client # from staff #8. The			week for one month and then weekly ongoing to observe me times to ensure active treatme and that diet plans are being followed. In addition, medical administration observations we done to ensure all medication administration protocols are be	eal ent tion ill be
	was not aware the n	PM, staff #8 indicated she nedication was supposed to be uice. Staff #8 stated she		followed. Responsible Parties: Area Director, QIDP (Program Director), Nurse	
	client #4's record was Medical Appointme	PM, a focused review of as conducted. An 8/30/21 ent Form indicated, " ulfate to BID (twice a day).			

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	OF CORRECTION	IDENTIFICATION NUMBER: 15G300			COMPLETED 10/05/2021	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE PIKE ST		
TRANSIT	TIONAL SERVICES	SUB LLC		NSVILLE, IN 46151		
(X4) ID PREFIX TAG	(EACH DEFICIENC REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) ice"	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
	On 9/28/21 at 10:55 stated the staff not k needing to be admin "a staff training issu On 9/28/21 at 10:43 staff not knowing at to be administered w training issue." The juice reduced the ris 2) On 9/27/21 at 3:4 #4's finances was confollowing: -On 9/5/21, client #4 sandwich, large swe and a chicken sandw -On 9/10/21, client #4 cheeseburger meal, creme pie and a stratenesseburger meal, pieOn 9/24/21, client #4 cheeseburger, mediute and a glazed dom On 9/28/21 at 2:54 I	AM, the Area Director nowing about the medication istered with orange juice was e." AM, the nurse stated the rout the medication needing with orange juice was "a staff nurse indicated the orange k of constipation. By PM, a review of client nducted and indicated the purchased a deluxe chicken et tea, strawberry creme pie wich. A purchased a 2 large sweet tea, strawberry wberry smoothie. A purchased a 2 large sweet tea, and an apple A purchased a 2 large sweet tea, and an apple				
	the following: An 8/12/21 Indiana	Mentor/TSI Medical indicated, "Cut back on sugar				
	Client #4's 8/12/21 I he was on an 1800 c	Physician's Orders indicated alorie, low fat, low				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV		SURVEY			
AND PLAN	D PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDII		JILDING	DING 00 COMP.		ETED	
		15G300	B. WING			10/05/2021	
NAME OF B	DOLUBED OF GLIPPI IED	<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			110 W I	PIKE ST		
TRANSIT	IONAL SERVICES	SUB LLC		MARTINSVILLE, IN 46151			
(X4) ID		FATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECT			(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ſΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY		DATE
	*	entrated sweets, and no					
	added salt.						
	On 0/28/21 at 1:25 I	PM, the nurse stated client					
		"a little much." The nurse					
	-	eeded to assist client #4 to					
		es according to his diet. The					
	-	"staff training issue."					
	9-3-3(a)						
W 0195	483.440						
D	ACTIVE TREATM						
Bldg. 00		nsure that specific active					
		requirements are met.	337.6	105	An IDT will be scheduled for C	liont	11/04/2021
		on, record review and clients living in the group	W (195	#3 with the outside service	lient	11/04/2021
		4, #5, #6 and #7), the facility			provider to determine if change	26	
	·	ondition of Participation:			are needed for his program pla		
		ervices. The facility failed to			If changes are made, staff in the		
		ervices met the needs of			home will be trained on the		
		ied Intellectual Disabilities			changes.		
) integrated, coordinated and			QIDP will have monthly contact	:t	
		s' program plans, staff			(either face to face or		
		y based training in regard to			electronically) with outside ser	vice	
	-	Ferrous sulfate (iron			providers to ensure issues are		
	supplement) to be a	dministered with orange juice			addressed timely.		
	and client #4's diet of	orders, staff implemented the			The QIDP will be retrained to		
	clients' program plan				ensure staff implement training	j	
	-	plementation of the clients'			objectives as written and		
		bjectives, and the clients			document skill data from the		
	-	poured their drinks and			completed training objectives.		
	participated in break	ctast preparation.			Nurse will retrain Program	ina	
	Eindings in abids:				Supervisor and staff on review the MAR and following instruct	•	
	Findings include:				administering medications.	10115	
	1) Please refer to W	/120. For 1 of 1 client (#3)			Nurse will train Program		
		le services workshop #1, the			Supervisor and staff on all diet		
		ure the outside services met			plans in the home.		
	the needs of client #				Supervisory staff will complete		
					l ' ' '		

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STATEMEN	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: A. BUILDING 00		00	COMPL	ETED	
		15G300	B. W	NG		10/05/	2021
				OTTO FEET A	ADDRESS CHANGE THE SAME CODE		
NAME OF P	ROVIDER OR SUPPLIER	t e e e e e e e e e e e e e e e e e e e			ADDRESS, CITY, STATE, ZIP CODE		
					PIKE ST		
TRANSIT	TIONAL SERVICES	SUB LLC		MARTIN	NSVILLE, IN 46151		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DECLIDED IN AN OF CORRECTION		(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 APPROPRIAT		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
		·			three observations per week for	or	
	2) Please refer to W	V159. For 3 of 3 clients in			one month, two observations p		
	· ·	and #3), the Qualified			week for one month and then)Ci	
		ties Professional (QIDP)				ol.	
					weekly ongoing to observe me		
	_	coordinate and monitor the			times to ensure active treatme	nι	
	clients' program pla	ns.			and that diet plans are being		
	A = -				followed. In addition, medicati	on	
	· ·	V189. For 1 of 4 additional			observations will be done to		
	· /·	ility failed to ensure staff			ensure all medication		
	_	ey based training in regard to			administration protocols are be	eing	
		Ferrous sulfate (iron			followed.		
	supplement) to be a	dministered with orange juice			QIDP will retrain staff on the n	eed	
	and client #4's diet of	orders.			for active treatment and follow	ing	
					program plans. QIDP will obse	erve	
	4) Please refer to W	V196. For 3 of 3 clients in			during weekly visits to ensure		
	the sample (#1, #2 a	and #3), the facility failed to			active treatment is occurring.		
	ensure the clients re	eceived a continuous,			Client #2 will start going to the		
		sistent active treatment			Day Program beginning 10.25		
		the implementation of the			on a gradual basis and increas		
	clients' program pla	-			over time.		
	onome program pa				Responsible Parties: Area		
	5) Please refer to W	V249. For 3 of 3 clients in			Director, QIDP (Program		
	· ·	and #3), the facility failed to			Director), Nurse		
	* ` `	ented the clients' program			Directory, italise		
	plans as written.	ented the chefts program					
	pians as written.						
	6) Planca refer to W	V252. For 3 of 3 clients in					
	· ·						
	* ` `	and #3), the facility failed to					
		ented the implementation of					
	the clients' goals and	d training objectives.					
	7) DI	7400 E 7 67 1					
	· ·	V488. For 7 of 7 clients					
		nome (#1, #2, #3, #4, #5, #6					
		failed to ensure the clients					
		poured their drinks and					
	participated in breal	kfast preparation.					
	9-3-4(a)						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
	15G300	B. W	ING		10/05/	2021
NAME OF PROVIDER OR SUPPLIE TRANSITIONAL SERVICE		STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151				
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY 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)	ΤE	(X5) COMPLETION DATE
ACTIVE TREAT Each client must treatment progra aggressive, consprogram of spect treatment, health services describ directed toward: (i) The acquisiting necessary for the much self determas possible; and (ii) The prevent regression or lost functional status Based on observation interview for 3 of and #3), the facility received a continuactive treatment programment implementation of Findings include: 1) Observations whome on 9/27/21 in 9/28/21 from 6:27 observations, the function. When the alarm did not self-unction was conducted in the self-unction of the self-unction was conducted in the self-unction in the heal alarms."	receive a continuous active m, which includes sistent implementation of a alized and generic training, a services and related ed in this subpart, that is on of the behaviors e client to function with as hination and independence ion or deceleration of s of current optimal	W	0196	The QIDP will be retrained to ensure staff implement training objectives as written and document skill data from the completed training objectives. staff will be trained on documenting the implementati of training objectives as writter. The Program Supervisor and QIDP will review tracking of training objectives at least we to ensure documentation is be completed. Corrective action vibe completed with staff if documentation is not complete as required. QIDP will retrain staff on the nifor active treatment and follow the program plans. QIDP will observe during weekly visits to ensure active treatment is occurring. Koorsen was contacted and an estimate was received and	All on n. ekly ing vill ed eed ing	11/04/2021

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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 10/05/2021
	PROVIDER OR SUPPLIER FIONAL SERVICES SUB LLC	110 W	ADDRESS, CITY, STATE, ZIP CODE PIKE ST NSVILLE, IN 46151	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	indicated the exterior door alarms should be on due to client #2's elopement plan. 2) On 9/27/21 from 3:37 PM to 5:56 PM, an observation was conducted at the group home. At 5:31 PM, client #2 sat down to eat his dinner. There was no staff present for 2 minutes while client #2 ate dinner. At 5:33 PM, client #2 gagged and threw up a little bit of liquid onto a plate and food. He continued to eat. Client #2 ate and drank quickly with no redirection from the staff. At 5:36 PM, client #2 finished his meal and left the table. Client #2 was not reminded to eat slowly, take small bites, take his time to chew and swallow between bites, wipe face with napkin every two or three bites and not gulp his drink. On 9/28/21 from 6:27 AM to 8:17 AM, an observation was conducted at the group home. At 6:38 AM, client #2 was told it was time for breakfast. Client #2 ate quickly with no redirection from staff. He finished his breakfast at 6:42 AM. Client #2 was not reminded to eat slowly, take small bites, take his time to chew and swallow between bites, wipe face with napkin every two or three bites and not gulp his drink. On 9/28/21 at 11:51 AM, a review of client #2's record was conducted. Client #2's 4/28/21 ISP indicated, "Staff will have [client #2] in view and remind him to eat slowly or take smaller bites, take time to chew his food and swallow between bites. Encourage to wipe face with napkins every two to three bites. If [client #2] will not slow down, pull plate one plate space away, after he clears his mouth, return plate. When drinking, prompt to drink slowly, not gulp. Have him breathe every three to four swallows. If [client #2] will not stop gulping, place your		approved for a new door alarm system to be installed on 10/13/21. New door alarms we installed as soon possible. In mean time staff have been instructed to keep the individual line of site to ensure his safety. Nurse will retrain Program Supervisor and staff on review the MAR and following instructional administering medications. Nurse will train Program Supervisor and staff on all die plans in the home. Supervisory staff will complete three observations per week for one month, two observations week for one month and then weekly ongoing to observe meatimes to ensure active treatment and that diet plans are being followed. Client #2 will start going to the Day Program beginning 10.25 on a gradual basis and increasover time. Responsible Parties: Area Director, QIDP (Program Director), Nurse	ill be the al in /. // ving tions t eor per eal ent

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ	ULTIPLE CO. JILDING	NSTRUCTION	(X3) DATE COMPL		
AND PLAN	OF CORRECTION	15G300	B. WI		00	10/05	
		15G300	B. W1		_	10/05/	/2021
NAME OF F	PROVIDER OR SUPPLIEF	8			DDRESS, CITY, STATE, ZIP CODE		
TD 4 1 10 17					PIKE ST		
TRANSII	TIONAL SERVICES	SUB LLC		MARIIN	NSVILLE, IN 46151		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		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	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		to remove drink from					
	mouth"						
	On 0/29/21 at 11.22	AM the AD indicated alient					
		2 AM, the AD indicated client we been implemented as					
	written.	ve been implemented as					
	written.						
	3) Observations we	ere conducted at the group					
		om 3:37 PM to 5:56 PM and					
	9/28/21 from 6:27 A	AM to 8:17 AM. With the					
	exception of meals,	throughout the observations					
		elient #2 was in his bedroom					
		as not asked to participate in					
		2 was not provided activities					
		nt #2 was not prompted to					
		m. Client #2 was not					
	_	meaningful activities to					
	engage in througho	ut the observations.					
	On 9/28/21 at 7:05	AM, staff #3 stated client #2					
		the day. Don't try to take him					
		n. He goes out to eat on					
		here are 2 staff." Staff #3					
	stated she did not in	nteract with client #2 "very					
	much" to reduce the	e chance of him having a					
	maladaptive behavi	or.					
		AM, a review of client #2's					
		ed. Client #2's 4/28/21 ISP					
	indicated he had the	e following training					
	objectives:						
	-Daily, [client #2] y	vill go to the dining room for					
	med pass.	<u>6- </u>					
	_	rticipate in a community					
	outing at least 3 tim	-					
		vill practice one sign to					
		nication with others.					
	-Bimonthly, [client	#2] will withdraw from his					
	bank account and si	ign his name to the withdrawal.					
	I						I

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	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		INSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	
		15G300	B. W	ING		10/05	/2021
NAME OF F	DOLUBED OR GUIDNI IEI		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF F	PROVIDER OR SUPPLIEF	C .		110 W F	PIKE ST		
TRANSIT	TIONAL SERVICES	SUB LLC		MARTIN	NSVILLE, IN 46151		
(X4) ID	CHMMADV	TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
IAG				IAG	DEI IOIE NO 1		DATE
	bedding in the wash	will put his clothes and					
		vill take a drink and/or wipe					
		upkin in between bites of food.					
	ilis ilioutii witti a ila	ipkin in between bites of food.					
	Client #2's 10/2/20	Behavior Support Plan (BSP)					
		at #2] is not employed, and					
	_	ramming at the group home.					
		constant supervision					
		[Client #2] can communicate					
		ords and phrases, and gestures.					
		ssistance with completing					
		ving. [Client #2] enjoys					
		riding in the van, jumping,					
		exercising. [Client #2] can					
	_	over things, which can result					
		aggression towards self and					
	others, and property	destruction. Many of [client					
	#2's] behaviors occ	ur as a result of him					
	obsessing over som	ething, whether he has access					
	to the item or not	[Client #2] engages in					
	aggression towards	self, aggression towards					
	others, destructive	to property, disruptive					
	behavior, and elope	ement. These behaviors					
	typically occur in a	chain and are results of					
	[client #2] obsessin	g over access to					
	items/activities [Client #2] enjoys staff					
	, ,,	ically does not ask for it.					
		ttention throughout the day					
		acing maladaptive behaviors.					
		gaged in enriching activities					
		to reduce incidents of					
	maladaptive behavi	ors"					
	On 0/28/21 at 11:22	2 AM, the AD indicated client					
		ve been implemented as					
	written.	ve ocen impiemented as					
	witten.						
	4) On 9/28/21 from	n 6:27 AM to 8:17 AM, an					
		nducted at the group home.					
	55551 varion was co.	nauctou at the group nome.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPL	
		15G300	B. WING			10/05/	2021
NAME OF B	ROVIDER OR SUPPLIER		ST	REET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SOLI LIER		1	10 W P	IKE ST		
TRANSIT	IONAL SERVICES	SUB LLC	М	ARTIN	SVILLE, IN 46151		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	II		DROWINEDIC DI ANI OE CORRECTIONI		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PRE	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA"	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TA	AG	DEFICIENCY)		DATE
	From 6:27 AM to 8	:03 AM, the basement door					
	was unlocked. This	s affected client #2.					
	staff unlocked the b	AM, staff #3 indicated the assement door when they it at the end of their shift due ement to get food.					
	basement door need	AM, the AD told staff #3 the led to be locked at all times. staff #3 to lock the door.					
	record was conduct indicated, "Due to [AM, a review of client #2's ed. Client #2's 4/28/21 ISP client #2's] elopement and a behavior basement door en locked"					
		2 AM, the AD indicated client we been implemented as					
	observation was con indicated the follow	n 3:37 PM to 5:56 PM, an inducted at the group home and ring medication ing objectives were not					
	his medication from	:16 PM, client #2 received a staff #8 in his bedroom. rompted to go to the dining attion.					
	record was conduct	AM, a review of client #2's ed. Client #2's 4/28/21 ISP client #2] will go to the dining					
		2 AM, the AD indicated client we been implemented as					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	· ·	E SURVEY PLETED	
ANDILAN	OF CORRECTION	15G300	B. WING	00	- 1	5/2021
		130300	_		-	5/2021
NAME OF F	PROVIDER OR SUPPLIEF	₹		T ADDRESS, CITY, STATE, ZIP CC V PIKE ST	DDE	
TRANSIT	TIONAL SERVICES	SUBITC		TINSVILLE, IN 46151		
			ID	T		(V.5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE AF DEFICIENCY)	PPROPRIATE	DATE
	written.	,				
	l '	m 6:27 AM to 8:17 AM, an				
		nducted at the group home and				
	indicated the follow	ving medication iing objectives were not				
	implemented.	ing objectives were not				
	1					
		AM, client #1 received his				
		taff #5. Client #1 was not				
		to state the name and purpose				
	of all of his medica	tions.				
	On 9/28/21 at 11:00	O AM, a review of client #1's				
		red. Client #1's 11/24/20 ISP				
		during a med pass, [client #1]				
		of all his medications and the				
	reasons prescribed.	"				
	On 9/28/21 at 11·23	2 AM, the AD indicated client				
		ve been implemented as				
	written.					
		5 AM, client #3 received his taff #8. Client #3 was not				
		to state the name and purpose				
	of one of his medic					
	3 4.5					
		1 PM, a review of client #3's				
		ed. Client #3's 7/24/20 ISP				
		daily, [client #3] will state the				
	prescribed"	medications and the reason				
	preserioed					
	On 9/28/21 at 11:22	2 AM, the AD indicated client				
		ve been implemented as				
	written.					
	6) On 0/27/21 f	2.27 DM to 5.56 DM				
		n 3:37 PM to 5:56 PM, an nducted at the group home.				
	Josef varion was col	madeled at the group nome.	1			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G300	l í	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 10/05/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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)	ATE	(X5) COMPLETION DATE		
	At 5:31 PM, client # Client #1 ate his for from staff to slow d mouth with a napkin finished eating his d was not prompted the On 9/28/21 from 6:20 observation was cortant At 6:38 AM, client #1 prompts from staff t wipe his mouth with Client #1 finished eat AM. Client #1 finished eat AM. Client #1 was meal. On 9/28/21 at 11:00 record was conducted indicated, "Required down when eating bites of food when down with addition the food already preto verbally prompt [encouraging him to mouth with a napkin indicated, "At mean break between bites a napkin, take a dring on 9/28/21 at 11:22 #1's plan should have written. 7) Observations we home on 9/27/21 from 9/28/21 from 6:27 Ar 9/28/21 from 6:27	#1 started eating his dinner. Independent of the description of the de							

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ í	ULTIPLE CO UILDING	NSTRUCTION 00	(X3) DATE COMPL				
		15G300	B. W	ING		10/05/	2021		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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)	ATE	(X5) COMPLETION DATE		
	bicycle, go bowling	#1] will walk, ride his , and/or participate in some al exercise for at least 30							
		will make an appropriate ng a transaction in the							
		will practice using a key to t door to access the basement							
	-At least three times weekly, [client #1] will count out a specific amount of money using various denominations of bills and coins								
		AM, the AD indicated client we been implemented as							
	home on 9/27/21 fro 9/28/21 from 6:27 A	ore conducted at the group om 3:37 PM to 5:56 PM and AM to 8:17 AM. During the Illowing goals for client #3 ed:							
	-Three times weekly a minimum of 30 m	y, [client #3] will exercise for inutes							
		#3] will state the name of ons and the reason prescribed							
		will save \$10 from his mum, to be left in his count.							
	-Daily in the morning teeth	ng, [client #3] will brush his							

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO UILDING	00	(X3) DATE COMPL				
		15G300	B. W			10/05/			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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)	ATE	(X5) COMPLETION DATE		
		g, [client #3] will brush his							
		vill make his bed including s bed before sleeping.							
	-Daily, [client #3] w								
	-Weekly, [client #3] activity to participal	will choose a community te in.							
		AM, the AD indicated client we been implemented as							
	· ·	1:00 AM, a review of client ducted and indicated the							
	2021, July 2021, an Summaries indicate	y 2021, March 2021, June d August 2021 Action Plan d no data was documented for I training objectives.							
	indicated his goal fo	O21 Action Plan Summary or taking a break between ocumented 13 times.							
	•	21 Action Plan Summary or taking a break between ocumented 9 times.							
	The Qualified Intell Professional (QIDP program documenta summaries.) did not address the lack of							
		1:51 AM, a review of client ducted and indicated the							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUI A. BUII		NSTRUCTION 00	(X3) DATE : COMPL				
THEFTERN	or conduction	15G300	B. WIN		00	10/05/			
		130300			DDDFGG CITY CTATE TID CODE	10/03/	2021		
NAME OF F	PROVIDER OR SUPPLIEF	R		110 W F	DDRESS, CITY, STATE, ZIP CODE				
TRANSIT	TIONAL SERVICES	SUB LLC	MARTINSVILLE, IN 46151						
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	<u> </u>	ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	•	CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE		
	-Client #2's March	2021, June 2021, July 2021,							
		ction Plan Summaries							
	_	as documented for client #2's							
	goals and training o	bjectives.							
	-Client #2's Februar	ry 2021 Action Plan							
		his goal for practicing one							
	-	communication with others							
	was implemented 4	times. His goal to take a							
	-	is mouth with a napkin in							
		od was implemented 7 times.							
		mentation regarding his							
		to the dining room for his g his name on a withdrawal							
	_	pating in a community outing							
	three times per wee								
	_								
	-	021 Action Plan Summary							
	· ·	or practicing one sign to unication with others was							
		es. His goal to take a drink							
	-	uth with a napkin in between							
	-	nplemented 9 times. There							
		ion regarding his laundry goal,							
	going to the dining	room for his medications,							
		a withdrawal receipt, and							
		ommunity outing three times							
	per week.								
	-Client #2's May 20	21 Action Plan Summary							
		or practicing one sign to							
		inication with others was							
	-	es. His goal to take a drink							
	_	uth with a napkin in between							
		nplemented 5 times. His							
		he dining room for his uplemented one time. There							
		ion regarding his laundry goal,							
		room for his medications,							
	0,5								

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G300		` ′	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 10/05/	ETED			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151						
	TIONAL SERVICES			<u> </u>	NSVILLE, IN 40131				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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)	ιΤΕ	(X5) COMPLETION DATE		
		n a withdrawal receipt, and ommunity outing three times							
		lectual Disabilities) did not address the lack of ation on the monthly							
	/	2:21 PM, a review of client ducted and indicated the							
	2021 Action Plan S	21, July 2021, and August ummaries indicated no data r client #3's goals and training							
	indicated client #3's in the morning was #3's daily showering	2021 Action Plan Summary s daily goal to brush his teeth implemented 5 times. Client g goal was implemented 1 uily goal to make his bed was e.							
	indicated client #3's in the morning was Client #3's daily go evening was not im showering goal was	021 Action Plan Summary stail goal to brush his teeth implemented 12 times. all to brush his teeth in the plemented. Client #3's daily stant implemented. Client ake his bed was not							
	indicated client #3's in the morning was #3's daily goal to br was not implemente	221 Action Plan Summary s daily goal to brush his teeth implemented 9 times. Client rush his teeth in the evening ed. Client #3's daily s not implemented. Client							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G300		(X2) MULTIPI A. BUILDIN B. WING		NSTRUCTION 00	(X3) DATE : COMPL 10/05/	ETED			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE		
	#3's daily goal to maimplemented.	ake his bed was not							
	The Qualified Intell Professional (QIDP program documenta summaries.) did not address the lack of							
	(AD) indicated the of documented in the transport of the documentation was stated there was "not treatment implemented. AD indicated there for failing to documented on 9/10/21 of AD indicated the state 9/10/21. On 9/29/2 "there's not any acting going on. [Program documentation issue Last time (during 20 had to go there and what to do to documented. Staff clients' goals. Get of Need to be documented.	AM, the Area Director clients' goals should be imeframes indicated in the ed the lack of program an "on-going" issue." The AD of data to indicate active ted at the group home." The was no action taken with staff tent the implementation of the AD indicated the staff was on entering skill data. The aff was not trained prior to 1 at 2:01 PM, the AD stated we treatment teaching/training a Director/PD] aware of the es. Addressed last month. 120 recertification survey) I show the staff and tell them then them (the goals)." The coproof goals (are) being the redit for their hard work 1 thing. [PD] should have							
	out."	as she printed the monthlies							
W 0249 Bldg. 00		EMENTATION erdisciplinary team has t's individual program plan,							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3)			X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ЛLDING	00	COMPLETED	
		15G300	B. W	ING		10/05/	2021
				CTREET	ADDRESS SITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
					PIKE ST		
TRANSIT	TIONAL SERVICES	SUB LLC		MARTII	NSVILLE, IN 46151		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		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
	each client must r	eceive a continuous active					
	treatment program	n consisting of needed					
	interventions and	services in sufficient					
	number and frequ	ency to support the					
	achievement of th	e objectives identified in the					
	individual program	n plan.					
	Based on observation	on, record review and	W ()249	The QIDP will be retrained to		11/04/2021
	interview for 3 of 3	clients in the sample (#1, #2			ensure staff implement training	g	
	and #3), the facility	failed to ensure staff			objectives as written and		
	implemented the cli	ients' program plans as			document skill data from the		
	written.				completed training objectives.	All	
					staff will be trained on		
	Findings include:				documenting the implementat	ion	
					of training objectives as writte	n.	
	1) Observations we	ere conducted at the group			The Program Supervisor and		
	home on 9/27/21 fro	om 3:37 PM to 5:56 PM and			QIDP will review tracking of		
	9/28/21 from 6:27 A	AM to 8:17 AM. During the			training objectives at least wee	ekly	
	observations, the ex	terior door alarms did not			to ensure documentation is be	eing	
	function. When the	e exterior doors were opened,			completed. Corrective action v	vill	
	the alarm did not so	ound. This affected client #2.			be completed with staff if		
					documentation is not complete	ed	
		AM, a review of client #2's			as required.		
		ed. Client #2's 4/28/21			QIDP will retrain staff on the n		
		port Plan (ISP) indicated,			for active treatment and follow	ring	
		l's] elopement behavior, all			the program plans. QIDP will		
		me have activated door			observe during weekly visits to	ס	
	alarms."				ensure active treatment is		
					occurring.		
		AM, the Area Director (AD)			Koorsen was contacted and a	n	
		or door alarms should be on			estimate was received and		
	due to client #2's el	opement plan.			approved for a new door alarn	n	
	a) a 0/2=/2: 5				system to be installed on		
	1	n 3:37 PM to 5:56 PM, an			10/13/21. New door alarms w		
		nducted at the group home.			installed as soon possible. In	tne	
	· ·	#2 sat down to eat his dinner.			mean time staff have been		
	-	present for 2 minutes while			instructed to keep the individu		
		. At 5:33 PM, client #2			line of site to ensure his safety	/ .	
		p a little bit of liquid onto a			Nurse will retrain Program		
	-	continued to eat. Client #2			Supervisor and staff on review	-	
	ate and drank quick	ly with no redirection from			the MAR and following instruc	tions	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				DNSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	
		15G300	B. W	ING		10/05/	2021
			•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			110 W F	PIKE ST		
TRANSIT	TIONAL SERVICES	SUB LLC		MARTIN	NSVILLE, IN 46151		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NIE.	DATE
	the staff. At 5:36 P.	M, client #2 finished his			administering medications.		
		ole. Client #2 was not			Nurse will train Program		
	reminded to eat slov	vly, take small bites, take his			Supervisor and staff on all die	t	
		vallow between bites, wipe			plans in the home.		
	face with napkin ev	ery two or three bites and not			Supervisory staff will complete	Э	
	gulp his drink.				three observations per week f	or	
	_				one month, two observations		
	On 9/28/21 from 6:2	27 AM to 8:17 AM, an			week for one month and then		
	observation was con	nducted at the group home.			weekly ongoing to observe ac	tive	
	At 6:38 AM, client	#2 was told it was time for			treatment and that diet plans	are	
	breakfast. Client #2	2 ate quickly with no			being followed.		
	redirection from sta	ff. He finished his breakfast			Client #2 will start going to the	•	
		#2 was not reminded to eat			Day Program beginning 10.25		
	•	pites, take his time to chew			on a gradual basis and increa	se	
		en bites, wipe face with napkin			over time.		
	every two or three b	pites and not gulp his drink.			Responsible Parties: Area		
					Director, QIDP (Program		
		AM, a review of client #2's			Director), Nurse		
		ed. Client #2's 4/28/21 ISP					
		vill have [client #2] in view					
		eat slowly or take smaller					
	· ·	hew his food and swallow					
		ourage to wipe face with					
		o three bites. If [client #2]					
		pull plate one plate space s his mouth, return plate.					
	• •	mpt to drink slowly, not gulp.					
		wery three to four swallows.					
		ot stop gulping, place your					
		to remove drink from					
	mouth"	to remove drink from					
	On 9/28/21 at 11:22	AM, the AD indicated client					
		ve been implemented as					
	written.						
		ere conducted at the group					
		om 3:37 PM to 5:56 PM and					
		AM to 8:17 AM. With the					
	exception of meals,	throughout the observations					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SUF	RVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETI	ED
		15G300	B. W	ING		10/05/20	21
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	L		110 W F	PIKE ST		
TRANSIT	TIONAL SERVICES	SUB LLC			NSVILLE, IN 46151		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		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 APPROPRIATION OF THE APPROPRIATION	re C	OMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		lient #2 was in his bedroom					
		as not asked to participate in					
		2 was not provided activities					
		nt #2 was not prompted to					
		m. Client #2 was not					
	1 ~	meaningful activities to					
	engage in throughou	ut the observations.					
	On 0/29/21 at 7:05	AM staff #2 stated alignt #2					
		AM, staff #3 stated client #2 the day. Don't try to take him					
		n. He goes out to eat on					
		nere are 2 staff." Staff #3					
		iteract with client #2 "very					
		e chance of him having a					
	maladaptive behavi	_					
	maiadaptive ocnavi	01.					
	On 9/28/21 at 11:51	AM, a review of client #2's					
		ed. Client #2's 4/28/21 ISP					
	indicated he had the						
	objectives:	2 2					
	,						
	-Daily, [client #2] w	vill go to the dining room for					
	med pass.						
		rticipate in a community					
	outing at least 3 tim	-					
		vill practice one sign to					
		nication with others.					
		#2] will withdraw from his					
		gn his name to the withdrawal.					
		vill put his clothes and					
	bedding in the wash						
		vill take a drink and/or wipe					
	his mouth with a na	pkin in between bites of food.					
	Client #2's 10/2/20	Behavior Support Plan (BSP)					
		t #2] is not employed, and					
	_	ramming at the group home.					
		constant supervision					
		[Client #2] can communicate					
		rds and phrases, and gestures.					
	by using simple wo	ids and pinases, and gestures.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLE	ETED
		15G300	B. W	ING		10/05/2	2021
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L					
TDANCIT	TONAL CEDVICES	CLIPILLO			PIKE ST		
TRANSH	TIONAL SERVICES	SUB LLC		MARTIN	NSVILLE, IN 46151		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	DROVIDED'S BLAN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	T.E.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	IE	DATE
	[Client #2] needs as	sistance with completing					
		ving. [Client #2] enjoys					
	_	riding in the van, jumping,					
		xercising. [Client #2] can					
	-	ever things, which can result					
		aggression towards self and					
		destruction. Many of [client					
	#2's] behaviors occu						
	_	ething, whether he has access					
	-	[Client #2] engages in					
		self, aggression towards					
		o property, disruptive					
		ment. These behaviors					
	_	chain and are results of					
	[client #2] obsessing						
		Client #2] enjoys staff					
	_	cally does not ask for it.					
		ttention throughout the day					
		icing maladaptive behaviors.					
		-					
		gaged in enriching activities					
		to reduce incidents of					
	maladaptive behavi	ors"					
	0 0/20/21 + 11 22	NAME (LATE) TO A LATE (
		2 AM, the AD indicated client					
	-	ve been implemented as					
	written.						
	4) 0 - 0/20/21 0	. C.27 AM 4- 9.17 AM					
	· ·	n 6:27 AM to 8:17 AM, an					
		nducted at the group home.					
		:03 AM, the basement door					
	was unlocked. This	s affected client #2.					
	0.0/20/21 : 0.02	ADE 1 00 10 1 11 1 1 1					
		AM, staff #3 indicated the					
		asement door when they					
		t at the end of their shift due					
	to accessing the bas	ement to get food.					
	0.000						
		AM, the AD told staff #3 the					
		led to be locked at all times.					
	The AD requested s	staff #3 to lock the door.					
	i		1		İ		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G300		r í	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 10/05/	ETED	
	ROVIDER OR SUPPLIER			110 W F	.DDRESS, CITY, STATE, ZIP CODE PIKE ST ISVILLE, IN 46151		
				<u> </u>	NSVILLE, IN 40131		(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.IE	DATE
	record was conduct indicated, "Due to [property destruction from kitchen has be						
	On 9/28/21 at 11:22 AM, the AD indicated client #2's plan should have been implemented as written.						
	observation was con indicated the follow	n 3:37 PM to 5:56 PM, an inducted at the group home and ring medication ing objectives were not					
	his medication from	:16 PM, client #2 received a staff #8 in his bedroom. rompted to go to the dining ation.					
	record was conduct	AM, a review of client #2's ed. Client #2's 4/28/21 ISP client #2] will go to the dining					
		2 AM, the AD indicated client we been implemented as					
	observation was con indicated the follow	n 6:27 AM to 8:17 AM, an inducted at the group home and ving medication ing objectives were not					
	medications from st	AM, client #1 received his taff #5. Client #1 was not to state the name and purpose					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUI A. BUII		NSTRUCTION 00	(X3) DATE COMPL		
THEFTERN	or conduction	15G300	B. WIN		00	10/05/	
		100000			DDDEGG OFFI CTATE TID CODE	10/00/	2021
NAME OF F	PROVIDER OR SUPPLIEF	₹		110 W P	DDRESS, CITY, STATE, ZIP CODE		
TRANSIT	TIONAL SERVICES	SUB LLC			ISVILLE, IN 46151		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	of all of his medica	tions.					
	On 9/28/21 at 11:00) AM, a review of client #1's					
		red. Client #1's 11/24/20 ISP					
		during a med pass, [client #1]					
		of all his medications and the					
	reasons prescribed.	"					
	0.0/00/04						
		2 AM, the AD indicated client					
	#1's plan should have written.	ve been implemented as					
	written.						
-On 9/28/21 at 7:05 AM, client #3 received his							
	medications from staff #8. Client #3 was not						
	asked or prompted	to state the name and purpose					
	of one of his medic	ations.					
	0.0/00/01 + 10.03	1 D. 6					
		1 PM, a review of client #3's red. Client #3's 7/24/20 ISP					
		daily, [client #3] will state the					
		medications and the reason					
	prescribed"						
		2 AM, the AD indicated client					
	_	ve been implemented as					
	written.						
	6) On 9/27/21 from	n 3:37 PM to 5:56 PM, an					
	/	nducted at the group home.					
		#1 started eating his dinner.					
		od quickly with no prompts					
	from staff to slow d	lown, take a drink or wipe his					
		n in between bites. Client #1					
		dinner at 5:40 PM. Client #1					
	was not prompted to	hroughout the meal.					
	On 9/28/21 from 6.	27 AM to 8:17 AM, an					
		nducted at the group home.					
		#1 started eating his					
		1 ate his food quickly with no					
		- ·	1				

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AND PLAN	D PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G300 A. BUILDING 00 B. WING			COMPLETED 10/05/2021		
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE PIKE ST		
TRANSIT	TIONAL SERVICES	SUB LLC		NSVILLE, IN 46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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)	ΓE	(X5) COMPLETION DATE
	wipe his mouth with Client #1 finished ea	o slow down, take a drink or a napkin in between bites. ating his breakfast at 6:44 not prompted throughout the				
	record was conducted indicated, "Requires down when eating. bites of food when eating the food already present to verbally prompt [encouraging him to mouth with a napking indicated, "At means break between bites a napkin, take a dring on 9/28/21 at 11:22 #1's plan should have written. 7) Observations we home on 9/27/21 frog 9/28/21 from 6:27 A	AM, a review of client #1's ed. Client #1's 11/24/20 ISP is prompting regarding slowing [Client #1] consumes large eating. [Client #1] stuffs his eal food prior to swallowing sent in his mouth. Staff are client #1] to slow down by take a drink or wipe his en in between bites." The ISP eals, [client #1] will take a of food (wipe his mouth with eak, put down his fork)" AM, the AD indicated client we been implemented as The conducted at the group of 3:37 PM to 5:56 PM and the conducted at the group of				
	-2x weekly, [client # bicycle, go bowling other type of physic minutesWeekly, [client #1] greeting when maki community	llowing goals for client #1 ed: #1] will walk, ride his , and/or participate in some al exercise for at least 30 will make an appropriate ng a transaction in the will practice using a key to				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	ULTIPLE CO UILDING	00	(X3) DATE COMPL		
		15G300	B. W	ING		10/05/	
	PROVIDER OR SUPPLIER		<u> </u>	110 W F	ADDRESS, CITY, STATE, ZIP CODE PIKE ST NSVILLE, IN 46151	<u> </u>	
	SUMMARY S' (EACH DEFICIEN REGULATORY OR unlock the basemen -At least three times count out a specific various denomination On 9/28/21 at 11:22 #1's plan should have written. 8) Observations we home on 9/27/21 fro 9/28/21 from 6:27 A observations, the for were not implement -Three times weekly a minimum of 30 m -Once daily, [client one of his medication -Weekly, [client #3]	SUB LLC TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) It door to access the basement Is weekly, [client #1] will amount of money using ons of bills and coins It AM, the AD indicated client It we been implemented as It amount of money using ons of bills and coins It amount of money		110 W F	PIKE ST	TE	(X5) COMPLETION DATE
	teeth	ng, [client #3] will brush his					
	teeth	g, [client #3] will brush his					
	putting sheets on his	rill make his bed including s bed before sleeping.					
	-Daily, [client #3] w	vill take a shower					
	-Weekly, [client #3] activity to participat	will choose a community se in.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G300		(X2) MULTI A. BUILDI B. WING	PLE CONSTRUCTION ING 00	COM	(X3) DATE SURVEY COMPLETED 10/05/2021	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	II PRE TA	PROVIDER'S PLAN OF	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
		AM, the AD indicated client we been implemented as				
W 0252	483.440(e)(1) PROGRAM DOCL	IMENITATION				· ·
Bldg. 00	Data relative to ac criteria specified ir plan objectives mu measurable terms	complishment of the n client individual program ust be documented in				11/04/2021
	Based on record review and interview for 3 clients in the sample (#1, #2 and #3), the far failed to ensure staff documented the implementation of the clients' goals and train objectives. Findings include: 1) On 9/28/21 at 11:00 AM, a review of clients's record was conducted and indicated the following:		W 0252	ensure staff implen objectives as writte document skill data completed training staff will be trained documenting the in of training objective. The Program Supe QIDP will review training objectives at training objectives.	The QIDP will be retrained to ensure staff implement training objectives as written and document skill data from the completed training objectives. All staff will be trained on documenting the implementation of training objectives as written. The Program Supervisor and QIDP will review tracking of training objectives at least weekly to ensure documentation is being	
	2021, July 2021, and Summaries indicate client #1's goals and			be completed with documentation is n as required. QIDP will retrain sta	staff if ot completed	
	indicated his goal fo	O21 Action Plan Summary or taking a break between ocumented 13 times.		for active treatment the program plans. observe during wee ensure active treati	QIDP will ekly visits to	
	indicated his goal fo bites of food was do			occurring. Responsible Partic Director, QIDP (Propinector)		
	The Qualified Intell Professional (QIDP program documenta) did not address the lack of				

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	OF CORRECTION	IDENTIFICATION NUMBER: 15G300	A. BUILDING 00 B. WING		COMPLETED 10/05/2021
	PROVIDER OR SUPPLIER		110 W I	ADDRESS, CITY, STATE, ZIP CODE PIKE ST NSVILLE, IN 46151	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	2) On 9/28/21 at 11	:51 AM, a review of client ducted and indicated the			
	and August 2021 Ac	2021, June 2021, July 2021, etion Plan Summaries as documented for client #2's bjectives.			
	sign to increase his of was implemented 4 drink and/or wipe his between bites of food. There was no docum laundry goal, going medications, signing	his goal for practicing one communication with others times. His goal to take a is mouth with a napkin in od was implemented 7 times. The times are to the dining room for his goal is name on a withdrawal ating in a community outing			
	indicated his goal for increase his commutimplemented 3 time and/or wipe his moubites of food was im was no documentating going to the dining resigning his name on	or practicing one sign to nication with others was s. His goal to take a drink with a napkin in between aplemented 9 times. There on regarding his laundry goal, froom for his medications, a withdrawal receipt, and mmunity outing three times			
	indicated his goal for increase his commu- implemented 3 time	21 Action Plan Summary or practicing one sign to nication with others was s. His goal to take a drink th with a napkin in between			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		î ´	ULTIPLE CO JILDING	00	(X3) DATE COMPL		
		15G300	B. W	ING		10/05/	
	PROVIDER OR SUPPLIER		<u> </u>	110 W F	ADDRESS, CITY, STATE, ZIP CODE PIKE ST NSVILLE, IN 46151		
	SUMMARY S' (EACH DEFICIEN REGULATORY OR bites of food was in daily goal to go to ti medications was im was no documentati going to the dining signing his name or participating in a co per week. The Qualified Intell Professional (QIDP program documenta summaries. 3) On 9/28/21 at 12 #3's record was con following: -Client #3's June 20 2021 Action Plan S' was documented for objectives. -Client #2's March 2 indicated client #3's in the morning was #3's daily showering	SUB LLC TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) Inplemented 5 times. His the dining room for his plemented one time. There on regarding his laundry goal, room for his medications, a withdrawal receipt, and mmunity outing three times ectual Disabilities did not address the lack of tion on the monthly 2:21 PM, a review of client ducted and indicated the 21, July 2021, and August tummaries indicated no data or client #3's goals and training 2021 Action Plan Summary daily goal to brush his teeth implemented 5 times. Client ag goal was implemented 1	B. W	STREET A	PIKE ST	!	(X5) COMPLETION DATE
	-Client #2's April 20 indicated client #3's in the morning was Client #3's daily go evening was not im showering goal was #3's daily goal to m implemented.	daily goal to brush his teeth implemented 12 times. al to brush his teeth in the plemented. Client #3's daily not implemented. Client					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G300	(X2) MULTIP A. BUILDIN B. WING		nstruction 00	(X3) DATE : COMPL 10/05/	ETED
	PROVIDER OR SUPPLIER		110) W F	DDRESS, CITY, STATE, ZIP CODE PIKE ST ISVILLE, IN 46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	in the morning was #3's daily goal to br was not implemented showering goal was #3's daily goal to m implemented. The Qualified Intell Professional (QIDP program documenta summaries. On 9/28/21 at 11:27 (AD) indicated the documented in the t goals. The AD state documentation was stated there was "not treatment implement AD indicated there taken with staff for implementation of t indicated the staff wentering skill data. was not trained prio 2:01 PM, the AD state treatment teaching/t Director/PD] aware Addressed last mon recertification surve the staff and tell the them (the goals)." The proof goals (are) be needs to be docume credit for their hard documenting. [PD]	not implemented. Client ake his bed was not ectual Disabilities) did not address the lack of tion on the monthly AM, the Area Director clients' goals should be imeframes indicated in the ed the lack of program an "on-going" issue." The AD data to indicate active ted at the group home." The was no disciplinary action failing to document the he clients' plans. The AD ras trained on 9/10/21 on The AD indicated the staff or to 9/10/21. On 9/29/21 at ated "there's not any active raining going on. [Program of the documentation issues. th. Last time (during 2020 y) I had to go there and show m what to do to document The AD stated "there's no ing implemented. Staff inting the clients' goals. Get					

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		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		15G300	B. WING		10/05/2021	
			STREET .	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	8	110 W	PIKE ST		
	TIONAL SERVICES	SUB LLC	MARTI	NSVILLE, IN 46151		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	*	ICY 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	
W 0259	483.440(f)(2) PROGRAM MON	ITORING & CHANGE				
Bldg. 00		the comprehensive				
		ment of each client must be				
	reviewed by the in	nterdisciplinary team for				
	relevancy and upo	dated as needed.				
	Based on record rev	view and interview for 1 of 3	W 0259	QIDP will review and update C	FA 11/04/2021	
	clients in the sample	e (#3), the facility failed to		for Client #3.		
		omprehensive functional		QIDP will be retrained to revie		
		was reviewed for relevancy		and update CFA for all individu	uals	
	and updated at least	t annually.		at least annually.		
	Findings include:			Responsible Party: QIDP (Program Director)		
		PM, a review of client #3's				
		ed. Client #3's most recent				
	CFA was dated 6/10					
	documentation the updated since 6/10/2	CFA was reviewed and 20.				
	indicated client #3's	2 PM, the Area Director s CFA should be reviewed and				
	updated annually.					
	9-3-4(a)					
W 0260	483.440(f)(2)	ITODING & CHANGE				
Bldg. 00		ITORING & CHANGE the individual program plan				
Diag. 00		as appropriate, repeating				
		rth in paragraph (c) of this				
	section.	. F3. 2F (2) 2. 4.10				
		view and interview for 1 of 3	W 0260	QIDP will review and revise the	e 11/04/2021	
	clients in the sample	e (#3), the facility failed to	5255	ISP for Client #3.	11/01/2021	
	ensure client #3's In	ndividualized Support Plan		QIDP will be retrained to revie	w	
	(ISP) was revised at	t least annually.		and update ISPs for all individ	uals	
	Findings include:			at least annually. Responsible Party: QIDP		
	On 9/28/21 at 12:21	PM, a review of client #3's		(Program Director)		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G300		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 10/05/2021	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES 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 0262 Bldg. 00	ISP was dated 7/24/documentation the I 7/24/20. On 9/28/21 at 12:32 indicated client #3's annually. 9-3-4(a) 483.440(f)(3)(i) PROGRAM MONI The committee shimonitor individual manage inappropring programs that, in the committee, involve and rights. Based on observation interview for 3 of 3 and #3), the facility' committee (Human failed to review, apprestrictive program. Findings include: 1) On 9/28/21 at 11 #1's record was considered was considered in the I monitored the plan: psychotropic medic sharps and a locked a housemate from exproperty in the base indicated, in part, "I	SP was revised since PM, the Area Director ISP should be revised TORING & CHANGE ould review, approve, and programs designed to riate behavior and other the opinion of the exists to client protection on, record review and clients in the sample (#1, #2) is specially constituted Rights Committee/HRC) prove and monitor the clients'	W 0262	The QIDP and Behavior Analy will audit all the Behavior Sup Plans and take action to get guardian and HRC approval of any plans without approval. The QIDP, Behavior Analyst, a Director, Regional Director, ar State Clinical Director will meet evaluate current process for ensuring informed consent and HRC approval is obtained as required. Roles will be clarificated and changes will be made to streamline and improve the effectiveness of the process. Responsible Parties: Region Director, State Clinical Director, State Clinical Director, Behavior Analyst, QIDP (Program Director)	n Area and et to d ed

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G300	· /	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 10/05/	ETED
	PROVIDER OR SUPPLIER			110 W F	NDDRESS, CITY, STATE, ZIP CODE PIKE ST NSVILLE, IN 46151		
	TRANSITIONAL SERVICES SUB LLC			<u> </u>	40 VILLE, II 40 10 1		
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	have activated door Approval have beer housemates' plans, to objects in the home [client #1] as necess knives and scissors, have been obtained, elopement and prop basement door from HRC approval has to Client #1's 2/10/21 included the use of medications (Buspin olanzapine as an and depression). There was no docur reviewed, approved restrictive ISP and I #2's record was con ISP included the fol interventions with m reviewed, approved "Describe form of 24-hour supervision eyesight of a staff p hours, except when his bedroom Staf with putting on his se entering the van and safety harness to the bench seat on driver [Client #2] will put prompts over the sa motion, one staff m back of van based of	alarms. Guardian and HRC a obtained. Per two the knives, scissors, and sharp are locked. Staff will assist sary when accessing the Guardian and HRC Approval Due to housemate's erty destruction behavior a kitchen has been locked. been obtained." Behavior Support Plan (BSP) restraints and psychotropic rone for depression, ti-psychotic and Sertraline for mentation the facility's HRC and monitored client #1's 3SP. 1:51 AM, a review of client ducted. Client #2's 4/28/21					DATE

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	OF CORRECTION IDENTIFICATION NUMBER: 15G300	(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 10/05/2021
	PROVIDER OR SUPPLIER TIONAL SERVICES SUB LLC	STREET A 110 W I MARTIN		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
	member should remain with [client #2] in the van within arm's reach while [client #2] continues to be seated in the third bench seat by the window. All van doors should be locked whenever [client #2] is riding in the van Due to [client #2's] elopement behavior, all exit doors in the home have activated door alarms. [Client #2] also has and alarm and bells that are placed on the door knobs of his bedroom doors. Guardian and HRC approval have been obtained. Per [client #2's] and a housemate's plans, the knives, scissors, and sharp objects in the home are locked. Staff will assist [client #2] as necessary when accessing knives, scissors, and other sharp objects. Guardian and HRC approval have been obtained. Due to [client #2's] elopement and property destruction behavior basement door from kitchen has been locked. HRC approval has been obtained." Client #2's 10/2/20 BSP included the following restrictive interventions with no documentation the HRC reviewed, approved and monitored the plan: guardian, restraints, psychotropic medications (Buspirone for anxiety, Clonazepam as a sedative, Clozapine as an antipsychotic and Lorazepam for aggression). There was no documentation the facility's HRC reviewed, approved and monitored client #2's restrictive BSP. 3) On 9/28/21 at 12:21 PM, a review of client #3's record was conducted. Client #3's 7/24/20 ISP included the following restrictive interventions with no documentation the HRC reviewed, approved and monitored the plan: "24 hour supervision guardian Due to a housemate's elopement behavior, all exit doors in the home have activated door alarms.			

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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 10/05/2021	
	PROVIDER OR SUPPLIER TONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	Guardian and HRC approval have been obtained. Per [client #3's] and a housemate's plans, the knives, scissors, and sharp objects in the home are locked. Staff will assist [client #3] as necessary when accessing the knives and scissors. Guardian and HRC approval have been obtained. Due to housemate's elopement and property destruction behavior basement door from kitchen has been locked. HRC approval has been obtained" Client #3's 12/19/20 BSP included the following				
	restrictive interventions with no documentation the HRC reviewed, approved and monitored the plan: guardian, restraints, and psychotropic medications (Strattera for attention deficit hyperactivity disorder, Vraylar for oppositional defiant disorder, and Tenex for mood). There was no documentation the facility's HRC				
	reviewed, approved and monitored client #3's restrictive BSP. On 9/28/21 at 11:26 AM, the Area Director (AD) indicated none of the clients' plans were reviewed by the facility's HRC. The AD indicated the clients' restrictive program plans should be reviewed, approved and monitored by the HRC.				
W 0263 Bldg. 00	9-3-4(a) 483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.				
	Based on observation, record review and interview for 3 of 3 clients in the sample (#1, #2	W 0263	The QIDP and Behavior Analy will audit all the Behavior Supp		

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	OF CORRECTION IDENTIFICATION NUMBER: 15G300	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/05/2021
	PROVIDER OR SUPPLIER FIONAL SERVICES SUB LLC	110 W	ADDRESS, CITY, STATE, ZIP CODE PIKE ST NSVILLE, IN 46151	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	and #3), the facility's specially constituted committee (Human Rights Committee/HRC) failed to ensure written informed consent was obtained for the clients' restrictive program plans. Findings include: 1) On 9/28/21 at 11:00 AM, a review of client #1's record was conducted. Client #1's 11/24/20 Individualized Support Plan (ISP) indicated he had a guardian. The ISP included the following restrictive interventions with no documentation the facility obtained written informed consent for the plan: 24 hour supervision, psychotropic medications, door alarms, locked sharps and a locked basement door due to prevent a housemate from eloping and destroying property in the basement. Client #1's ISP indicated, in part, "Due to a housemate's elopement behavior, all exit doors in the home have activated door alarms. Guardian and HRC Approval have been obtained. Per two housemates' plans, the knives, scissors, and sharp objects in the home are locked. Staff will assist [client #1] as necessary when accessing the knives and scissors. Guardian and HRC Approval have been obtained. Due to housemate's elopement and property destruction behavior basement door from kitchen has been locked. HRC approval has been obtained." Client #1's 2/10/21 Behavior Support Plan (BSP) included the use of restraints and psychotropic medications (Buspirone for depression, olanzapine as an anti-psychotic and Sertraline for depression).		Plans and take action to get guardian and HRC approval o any plans without approval. The QIDP, Behavior Analyst, Director, Regional Director, ar State Clinical Director will mee evaluate current process for ensuring informed consent and HRC approval is obtained as required. Roles will be clarific and changes will be made to streamline and improve the effectiveness of the process. Responsible Parties: Region Director, State Clinical Director, Analyst, QIDP (Program Director)	Area ad et to d ed

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO JILDING	00	(X3) DATE COMPL		
MINDILMIN	or condition	15G300	B. W		00	10/05/	
		130300				10/03/	2021
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
TDANGIT	TIONAL SERVICES	SHBILC			PIKE ST		
TRANSITIONAL SERVICES SUB LLC				WARTII	NSVILLE, IN 46151		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROP		ATE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	guardian for his res	trictive ISP and BSP.					
	2) 0 0/20/21 4 11	51 AM					
	· ·	:51 AM, a review of client					
		ducted. Client #2's 4/28/21					
		d a guardian. The ISP					
		ing restrictive interventions					
		ion the facility obtained					
	written informed co	-					
		Supervision provided: s; to be supervised within					
	•	erson during all waking					
hours, except when he is in the bathroom or in							
his bedroom Staff need to assist [client #2]							
with putting on his safety harness prior to entering the van and then assist by securing the							
		e van once seated in the third					
		's side of van by the window.					
		his seat belt on with verbal					
		fety harness. When van is in					
		ember is to be seated in the					
		n the established seating					
		are exiting the van, one staff					
	-	ain with [client #2] in the van					
		while [client #2] continues to					
		d bench seat by the window.					
		d be locked whenever [client					
		van Due to [client #2's]					
		, all exit doors in the home					
	1	alarms. [Client #2] also has					
		that are placed on the door					
		m doors. Guardian and HRC					
		obtained. Per [client #2's]					
	* *	lans, the knives, scissors, and					
	_	home are locked. Staff will					
		necessary when accessing					
	-	d other sharp objects.					
		approval have been obtained.					
		elopement and property					
		r basement door from kitchen					
		RC approval has been					
		**					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G300		(X2) MULTIPLE CONSTRUCTION (X: A. BUILDING 00 B. WING			SURVEY LETED /2021	
	F PROVIDER OR SUPPLIEF		110 W	TADDRESS, CITY, STATE, ZIP COE I PIKE ST INSVILLE, IN 46151	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	restrictive intervent the facility obtained for the plan: guardimedications (Buspi as a sedative, Clozal Lorazepam for aggr. There was no docume written informed expandian for his results and selection of the plan: guardian for his results and a housemate's plant and should be and s	mentation the facility obtained onsent from client #2's trictive ISP and BSP. 2:21 PM, a review of client ducted. Client #3's 7/24/20 d a guardian. The ISP ing restrictive interventions tion the facility obtained onsent for the plan: "24 hour lian Due to a housemate's re, all exit doors in the home a alarms. Guardian and HRC obtained. Per [client #3's] oblans, the knives, scissors, and home are locked. Staff will necessary when accessing sors. Guardian and HRC obtained. Due to housemate's perty destruction behavior in kitchen has been locked. Staff will necessary when accessing sors. Guardian and HRC obtained. Due to housemate's perty destruction behavior in kitchen has been locked. Staff will necessary when accessing sors with no documentation of written informed consent				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G300		(X2) MUL A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE : COMPL 10/05/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
W 0331 Bldg. 00	written informed co guardian for his rest On 9/28/21 at 11:26 (AD) indicated the finformed consent for restrictive program facility needed to obsconsent for the restr 9-3-4(a) 483.460(c) NURSING SERVICTHE facility must poservices in accord Based on record revolutions in the sample services failed to enterecommended color Findings include: On 9/28/21 at 11:00 record was conducted following: -On 9/21/20, client in the 9/21/20 Medical "please check (with (due to) chronic and color on 3/30/21, client in the 3/30/21 Medical the 3/30/21 Medical the 3/30/21 Medical manual color on 3/30/21, client in the 3/30/21 Medical decoration of the 3/30/2	rovide clients with nursing ance with their needs. iew and interview for 1 of 3 e (#1), the facility's nursing sure client #1 had a loscopy. AM, a review of client #1's ed and indicated the #1's physician indicated on Appointment Form, th) family about colonoscopy	W 03	31	Nurse has reached out to the physician and received an updated order for a colonosco for Client #1. The procedure is scheduled for mid-November. The Nurse with work with the program staff to ensure Client completes the procedure as ordered. Responsible Party: Nurse, QIDP (Program Director)	5	11/04/2021

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00 COMPLET						
ANDILAN	or correction	15G300	B. WIN		00	10/05/		
		136300	D. WII			10/03/	2021	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
TDANCIT	IONAL SERVICES	CLIPILIC	110 W PIKE ST					
IKANSH	TIONAL SERVICES	SUB LLC	MARTINSVILLE, IN 46151					
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
		PM, the Area Director (AD)						
		il, "[Nurse] is trying to make this to happen because the						
	* *	from [former nurse] was that						
	_	to allow him to complete the						
	-	ey are not guardians, [nurse]						
	-	doctor's office to get it						
	_	er recommendations."						
		AM, the AD indicated client						
	#1's physician recon	nmended a colonoscopy.						
	The AD stated client #1 "should have it."							
	0.00001.11.50.11.1							
On 9/30/21 at 11:58 AM, the nurse indicated she spoke to the former nurse about client #1's								
	-	former nurse indicated client						
		to allow client #1 to have a						
	-	surse indicated the former						
		nent anything regarding the						
		ne record. The nurse stated,						
	"She didn't documen	nt anything." The nurse stated						
	she needed to get an	other order for a						
		"order way outdated." The						
		found documentation of the						
	colonoscopy being r	recommended since 2019.						
	9-3-6(a)							
W 0368	483.460(k)(1)							
5556	DRUG ADMINIST	RATION						
Bldg. 00		ug administration must						
3	_	gs are administered in						
	compliance with th	e physician's orders.						
	Based on record rev	iew and interview for 1 of 3	W 03	868	The Nurse completed annual		11/04/2021	
		e (#3) and one additional			recertification training for			
		ity failed to ensure staff			medication administration and			
	administered the clie	ents' medications as ordered.			health management 8.2021 wi	th		
	F: 1:				staff in the home.			
	Findings include:				Nurse will retrain Program Supervisor and staff on review	ina		
					oupervisor and stair on review	ıı ıy		

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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. B	A. BUILDING <u>00</u> COMPLETE		ETED	
		15G300	B. W	B. WING 10/05/2021			2021
				CTDEET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIE	R		1			
TDANCIT	TONAL CEDVICE	S CLID LL C			PIKE ST		
TRANSITIONAL SERVICES SUB LLC			WARTI	NSVILLE, IN 46151			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	On 9/27/21 at 11:5	9 AM, a review of the			the MAR and following instruc	tions	
	facility's incident re	eports was conducted and			administering medications.		
	indicated the follow	ving:			Nurse will train Program		
					Supervisor and staff on all die	t	
	1) On 7/28/21 at 8	:00 PM, client #3 did not			plans in the home.		
	receive his Naltrex	one (anxiety), Guanfacine			Supervisory staff will complete	е	
	(attention deficit h	yperactivity disorder), Vraylar			three observations per week for	or	
	(bipolar disorder),	and Cetirizine (allergies).			one month, two observations (per	
					week for one month and then		
	2) On 7/30/21 at 8	:00 PM, client #6 did not			weekly ongoing to observe me	eal	
	receive his Metopr	olol Tartrate (high blood			times to ensure active treatme	ent	
	pressure).				and that diet plans are being		
					followed. In addition, medicat	ion	
	3) On 8/1/21, 8/2/21, 8/3/21, 8/4/21 and 8/5/21				observations will be done to		
	at 8:00 AM, client	#3 received vitamin D3.			ensure all medication		
		der to receive Vitamin D3 one			administration protocols are be	eing	
	time per week.				followed.		
					Responsible Parties: Area		
	· ·	:00 AM it was discovered			Director, QIDP (Program		
		a double dose of Strattera			Director), Nurse		
		yperactivity disorder) from					
		The report indicated, "					
		d a daily dose of 200 mg					
		attera/atomoxetine for the					
	-						
	-	cribed dose of 100 mg per					
	day"						
	administered as ord	dered.					
	9-3-6(a)						
	, , , ,						
W 0369	483.460(k)(2)						
	DRUG ADMINIS	FRATION					
Bldg. 00							
	-	ugs, including those that are					
		, are administered without					
	error.						
W 0369 Bldg. 00	time period of 08/0 instead of the presoday" On 9/27/21 at 12:4 indicated the client administered as ord 9-3-6(a) 483.460(k)(2) DRUG ADMINIST The system for drassure that all draself-administered	p9/2021 to 08/14/2021 cribed dose of 100 mg per 5 PM, the Area Director s' medication should be dered. FRATION rug administration must ugs, including those that are					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G300		î î	ILDING	instruction 00	(X3) DATE : COMPL 10/05/	ETED	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES 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 APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
W 0440	Based on observation interview for 1 of 2 client #2 during the staff failed to admin (for high ammonia I Findings include: On 9/27/21 from 3:3 observation was core At 5:16 PM, client # milliliters from staff On 9/28/21 at 11:51 record was conducted Physician's Orders in (gram)/15 ml sol (so mouth 3 times a day #2 did not have an of 5:00 PM. On 9/28/21 at 1:53 I indicated client #2 r PM was a medicated administering the mound of the nurse indicated window to administ the window would be not at 5:00 PM. 9-3-6(a) 483.470(i)(1) EVACUATION DE	medications administered to evening medication pass, the ister client #2's Lactulose evel) at the prescribed time. 37 PM to 5:56 PM, an adducted at the group home. 42 received Lactulose 45 57 **8. AM, a review of client #2's ed. Client #2's 9/21/21 adicated, "Lactulose 10 gm oblution). Take 45 ml by 8am, 12pm, 8pm." Client ender to receive Lactulose at PM, the Area Director ecciving Lactulose at 5:00 en error due to the staff not edication at the ordered time. AM, the nurse stated "it is a not be given at 5:00 PM." the staff had an one hour er the medication however be 7:30 PM to 8:30 PM and	W 0		The Nurse completed annual recertification training for medication administration and health management 8.2021 wi staff in the home. Nurse will retrain Program Supervisor and staff on review the MAR and following instruct administering medications. Nurse will train Program Supervisor and staff on all diet plans in the home. Supervisory staff will complete three observations per week for one month, two observations per week for one month and then weekly ongoing to observe medimes to ensure active treatmed and that diet plans are being followed. In addition, medication administration protocols are befollowed. Responsible Parties: Area Director, QIDP (Program Director), Nurse	ing cions or per al nt	11/04/2021
Bldg. 00	Based on record rev	or each shift of personnel. iew and interview for 7 of 7 group home (#1, #2, #3, #4,	W 0	440	Staff were retrained on the expectation to conduct fire drill		11/04/2021

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC A. BUILDING	00	(X3) DATE SURVEY COMPLETED		
	15G300	B. WING		10/05/2021		
	PROVIDER OR SUPPLIER TONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	#5, #6 and #7), the facility failed to conduct quarterly evacuation drills for each shift of personnel. Findings include: On 9/27/21 at 3:40 PM, a review of the facility's evacuation drills was conducted and indicated the following affecting clients #1, #2, #3, #4, #5, #6 and #7: -During the evening shift (3:00 PM to 11:00 PM), there were no evacuation drills conducted from 9/27/20 to 2/9/21. -During the night shift (11:00 PM to 7:00 AM), there were no evacuation drills conducted from 9/27/20 to 3/14/21. On 9/27/21 at 3:51 PM, the Program Supervisor indicated the facility should conduct quarterly evacuation drills for each shift.		per policy on 10.20.21. QIDP will monitor and docume the completion of drills during weekly oversight visits and corrective action will be compl if drills are not completed as required. Responsible Party: QIDP (Program Director)			
	On 9/27/21 at 4:32 PM, the Area Director stated the facility should conduct evacuation drills "one per shift per quarter." 9-3-7(a)					
W 0460 Bldg. 00	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.					
	Based on record review and interview for 1 of 4 additional clients (#4), the facility failed to ensure client #4 followed his physician prescribed diet. Findings include:	W 0460	Nurse will train Program Supervisor and staff on all diet plans in the home. QIDP will monitor and docume observations during meal time ensure dietary plans and ment	ent s to		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G300		(X2) MUL A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE : COMPL 10/05/	ETED	
	ROVIDER OR SUPPLIER			110 W F	DDRESS, CITY, STATE, ZIP CODE PIKE ST ISVILLE, IN 46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
		PM, a review of client #4's cted and indicated the			are being followed during the weekly oversight visits. Responsible Party: QIDP (Program Director)		
	sandwich, large swe and a chicken sandword of 10/21, client is cheeseburger meal, creme pie and a strateneseburger meal, pie. -On 9/17/21, client is cheeseburger meal, pie. -On 9/24/21, client is cheeseburger, mediate and a glazed dor of 10/28/21 at 2:54 is client #4's record with the following: An 8/12/21 Indiana Appointment Form (and) starchy food Client #4's 8/12/21 he was on an 1800 of cholesterol, no concadded salt. On 9/28/21 at 1:25 is #4's purchases were indicated the staff in	#4 purchased a 2 large sweet tea, strawberry wberry smoothie. #4 purchased a 2 large sweet tea, and an apple #4 purchased a um french fries, large sweet nut. PM, a focused review of as conducted and indicated Mentor/TSI Medical indicated, "Cut back on sugar"					
W 0488	483.480(d)(4) DINING AREAS A	ND SERVICE					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>		00	COMPLETED	
15G300		15G300	B. WING			10/05/2021	
				CTDEET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER							
TRANSITIONAL SERVICES SUB LLC				110 W PIKE ST			
TRANSII	IONAL SERVICES	SOB LLC		WARTI	NSVILLE, IN 46151		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓF	COMPLETION
TAG				TAG DEFICIENCY)		DATE	DATE
Bldg. 00	The facility must a	ssure that each client eats					
	in a manner consis	stent with his or her					
	developmental lev	el.		0488			
	Based on observation	on and interview for 7 of 7	W (QIDP will retrain staff on the need for active treatment and following the program plans. QIDP will observe during weekly visits to ensure active treatment is		11/04/2021
	clients living in the	group home (#1, #2, #3, #4,					
	#5, #6 and #7), the f	facility failed to ensure the					
	clients served thems	selves, poured their drinks					
	and participated in b	preakfast preparation.					
					occurring.		1
	Findings include:				Responsible Party: QIDP		
					(Program Director)		
	On 9/27/21 from 3:3	37 PM to 5:56 PM, an					
	observation was cor	nducted at the group home.					
	At 5:19 PM, staff #6	was in the kitchen serving					
	food onto the clients	s' plates (meat loaf and baked					
	potatoes). Clients #	1, #2, #3, #4, #5, #6 and #7					
	did not serve themse	elves their food. Staff #6					
	carried condiments to the table. Staff #6 carried						
	the clients' plates to	the table.					
		27 AM to 8:17 AM, an					
		nducted at the group home.					
	Upon arrival, staff #3 was preparing breakfast. Staff #3 was setting the table, pouring cereal, and opening packages of Pop Tarts and placing them on the clients' plates. Client #6 was awake and available to assist however he was not asked to assist. At 6:35 AM, staff #3 poured client #6's						
		. At 6:38 AM, staff #3					
	poured client #1's milk onto his cereal after he						
		at 6:39 AM, client #2 entered					
	_	l staff #3 poured his milk. At					
	· ·	came downstairs and staff #3					
	-	6:41 AM, staff #3 poured					
		r he came downstairs. At					
		finished eating and left the					
		ned up spilled milk and					
crumbs off the table. Client #2 went		e. Client #2 went back to bed.					
	On 9/28/21 at 6:30 A	AM, staff #3 stated she					
			ı		1		

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AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G300	A. BU	2) MULTIPLE CONSTRUCTION A. BUILDING OO 3. WING		(X3) DATE SURVEY COMPLETED 10/05/2021	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES 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)	TE	(X5) COMPLETION DATE
W 9999 Bldg. 00	"works 6:00 AM to breakfast on Monda Wednesdays." On 9/28/21 at 1:53 I indicated the staff to be family style. The thought the dishes we the staff had the clie family style. The A be involved in meal themselves, pouring up. 9-3-8(a) State Findings The following Company for Persons with De Rule was not met: A) 460 IAC 9-3-1(b) The residential problem of the pr	2:00 PM. I make their ys, Tuesdays and PM, the Area Director (AD) old her they knew it needed to e AD indicated the staff were too hot to pass around so ents pass around the salad D indicated the clients should preparation, serving their own drinks and clean munity Residential Facilities velopmental Disabilities	WS	0999	The QIDP will retrain the Prog Supervisor on BDDS Incident Reporting to ensure medicatio errors are reported timely. Nurse will retrain Program Supervisor and staff on review the MAR and following instruct administering medications as ordered. Supervisory staff will complete three observations per week for one month, two observations per week for one month and then	ving tions	11/04/2021
	This state rule was rule and record revincident reports revifacility failed to rep	not met as evidenced by: iew and interview for 1 of 8 ewed affecting client #3, the ort medication errors to the nental Disabilities Services			weekly ongoing to ensure all medication administration protocols are being followed a medications are administered ordered. Reference checks have been documented for Staff #11. All new staff hired will have reference checks have been documented for Staff #11.	as	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G300		A. BUILDING 00 B. WING	COMPLETED 10/05/2021			
	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151				
TRANSIT (X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (BDDS) within 24 hours, in accordance with state law. Findings include: On 9/27/21 at 11:59 AM, a review of the facility's incident reports was conducted and indicated the following: On 8/14/21 at 8:00 AM (reported to BDDS on 8/16/21), it was discovered client #3 received a double dose of Strattera (attention deficit hyperactivity disorder) from 8/9/21 to 8/14/21. The report indicated, "[Client #3] received a daily dose of 200 mg (milligrams) of Strattera/atomoxetine for the time period of 08/09/2021 to 08/14/2021 instead of the prescribed dose of 100 mg per day" On 9/27/21 at 12:47 PM, the Area Director indicated incidents should be reported to BDDS within 24 hours. B) 460 IAC 9-3-2(c)(3) Resident Protections (c) The residential provider shall demonstrate that its employment practices assure that no staff person would be employed where there is: (3) conviction of a crime substantially related to a dependent population or any violent crime. The provider shall obtain, as a minimum, a bureau of motor vehicles record, a criminal history check as authorized in IC 5-2-5-5 [IC 5-2-5 was repealed by P.L.2-2003, Section 102, effective July 1, 2003. See IC 10-13-3-27.], and three (3) references. Mere verification of employment dates by previous employers shall not constitute a reference in compliance with this section.	MARTINSVILLE, IN 46151 ID PREFIX TAG PROVIDERS PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APP DEFICIENCY) Checks completed timely required. Corrective acting given to the Office Coord required documentation is maintained in personnel. Starting in October the A Director will be responsible audit all new files within 3 of hire and report during monthly AD Meeting. Responsible Party: Are Director, QIDP (Program Director), Nurse	as on will be inator if s not files. rea ole to 80 days the			

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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	REGULATORY OR LSC IDENTIFYING INFORMATION) Based on record review and interview, for 1 of 3 staff (#11) personnel files reviewed, the facility failed to ensure three reference checks for staff #11 were obtained prior to staff #11 working in the group home. Findings include: On 9/27/21 at 12:55 PM, a review of the employee files was conducted. Staff #11's file did not include three reference checks. On 9/27/21 at 1:16 PM, the Area Director indicated the facility should have obtained three reference checks for staff #11. 9-3-1(b) 9-3-2(c)(3)							

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