STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G300	A. BUILDING 00 B. WING	03/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL SERVICES SUB LLC	110 W PIKE ST MARTINSVILLE, IN 46151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for the investigation of complaint #IN00347983. This visit included a Covid-19 focused infection control survey. Complaint #IN00347983 - Substantiated. Federal and state deficiencies related to the allegation(s) were cited at W102, W104, W122, W149 and W157. Unrelated deficiencies cited. Survey dates: March 4, 8 and 9, 2021 Facility Number: 000819 Provider Number: 15G300 AIM Number: 100249100 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 3/16/21.	W 0000		
W 0102 Bldg. 00	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on observation, record review and interview for 7 of 7 clients living in the group home (A, B, C, D, E, F and G), the facility failed to meet the Condition of Participation: Governing Body. The facility's governing body failed to exercise operating direction over the facility by failing to ensure the clients were free from abuse, neglect, mistreatment and exploitation. The governing body failed to ensure staff immediately reported allegations of	W 0102	Staff in the home were retrained on the prevention of abuse, neglect, exploitation and mistreatment, reporting incidents timely and following/implementing corrective actions as written on 3/15/21. A second bid for the maintenance items listed in the survey and any other repairs that develop during	04/08/2021

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

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	abuse, neglect, mistreatment and exploitation to the administrator. The governing body failed to ensure appropriate corrective actions were implemented following two allegations of abuse, mistreatment and neglect. The governing body failed to ensure the home remained in good repair. The governing body failed to ensure the water temperature did not exceed 110 degrees Fahrenheit. The governing body failed to ensure the staff tested the water temperature on a regular basis. The governing body failed to address recurrent issues with bed bugs at the group home. The governing body failed to ensure client F's bed was in good repair. The governing body failed to ensure the former Program Supervisor was removed from the clients' bank accounts and current staff was added to the clients' bank accounts to ensure the clients could access their money. Findings include: 1) Please refer to W104. For 7 of 7 clients living in the group home (A, B, C, D, E, F and G), the facility's governing body failed to exercise operating direction over the facility by failing to ensure: 1) client F's bed remained in good repair, 2) client F's light switch was not falling out of the wall, 3) client F's bedroom wall did not have writing on the wall, 4) the staff took steps to address on-going issues with bed bugs in the group home, 5) the carpeting in the group home was replaced due to being discolored, frayed and stained, 6) client D's linoleum floor was free of tears and holes, 7) the upstairs hallway was free of holes, 8) client A's bedroom walls did not have holes in it, 9) there was a working thermometer in the group home to test the water temperature, and 10) the former Program Supervisor (PS) was removed from the clients'		repairs is in the process of being obtained and the home will be repaired once the contractor estimate is approved. Any future maintenance needs will be addressed timely following approval of estimates obtained for repairs. Staff in the home were retrained to monitor the water temperatures in the home on a regular basis for individuals' safety on 3/15/21. The temperatures have been obtained as required and are monitored and if the temperature increases about the required temperature, it will be immediately adjusted for health and safety. All individuals in the home except one are able to adjust their water temperature without assistance. Staff assist the other individual when he bathes/showers with adjusting his water temperature for his safety. Staff will continue to monitor the water temperatures weekly as required. Staff were retrained on following bed bug procedures at all times for health and safety of individuals in the home on 3/15/21. Treatments by an outside agency continue to be completed and will be completed until the bed bugs are remedied from the home. Staff are to assist each individual with deep cleaning their bedrooms each month to decrease the risk of bed bugs being in the home. This along with the bid for the	

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	bank accounts and a current staff added to the clients' accounts to ensure the clients had access to their bank accounts. 2) Please refer to W122. For 2 of 3 clients in the sample (A and C) and two additional clients (D and G), the governing body failed to meet the Condition of Participation: Client Protections. The facility's governing body failed to implement its policies and procedures to prevent abuse, mistreatment and exploitation of the client, ensure staff immediately reported allegations of abuse to the administrator, ensure an incident was reported to the Bureau of Developmental Disabilities Services within 24 hours, and ensure appropriate corrective actions were implemented following an investigation to ensure the staff was not smoking marijuana and mistreating the clients. This federal tag relates to complaint #IN00347983. 9-3-1(a)		repairs in the home to replace the flooring on the stairs and bedrooms, possibly a new railing for the stairs and upstairs hallway, will assist with the eradication of the bed bugs in the home. All individuals' totes of clothing have been removed from the dining room of the home and are now back in their bedrooms and will continue to be hung up when laundry is completed along with keeping their bedrooms as clean as possible to prevent the spread of bed bugs. A quote for Client F's bed had already been obtained prior to this survey. The bed has now been purchased and delivered to the home. The new bed was delivered on 3/24/21. The old bed has been discarded. The bed will monitored and will be replaced timely if it becomes in poor repair. The bank has been contacted to correct the changes in the access of staff to assist the individuals with their banking. The individuals still have access to their money in their RFMS accounts and are able to spend money as they desire. The local accounts are in the process of being closed and all their money made available to them in their RFMS accounts as they desire so they can make purchases as needed. Until that time, Indiana MENTOR will continue to work with the local bank to ensure past staff are	

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			removed from the accounts and current staff are added so the individuals have access to their money for any purchases they need/want to make. A weekly checklist will be completed by supervisory staff to observe items listed on this plan of correction are completed to ensure the home remains in good repair. Observations by supervisory staff will be completed at least 3 times per week for one month, twice a week for one month, weekly for one month and then at least monthly ongoing in the home to ensure the home is clean and in good repair, the water temperatures are being monitored and the beds are in good repair for health and safety. Persons Responsible: Program Supervisor, Program Director (QIDP), Area Director	
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review and interview for 7 of 7 clients living in the group home (A, B, C, D, E, F and G), the facility's governing body failed to exercise operating direction over the facility by failing to ensure: 1) client F's bed remained in good repair, 2) client F's light switch was not falling out of the wall, 3) client F's bedroom wall did not have writing on the wall, 4) the staff took steps to address	W 0104	A quote for Client F's bed had already been obtained prior to this survey. The bed has now been purchased and delivered to the home. The new bed was delivered on 3/24/21. The old bed has been discarded. The bed will monitored and will be replaced timely if it becomes in poor repair.	04/08/2021

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	on-going issues with bed bugs in the group home, 5) the carpeting in the group home was replaced due to being discolored, frayed and stained, 6) client D's linoleum floor was free of tears and holes, 7) the upstairs hallway was free of holes, 8) client A's bedroom walls did not have holes in it, 9) there was a working thermometer in the group home to test the water temperature, and 10) the former Program Supervisor (PS) was removed from the clients' bank accounts and a current staff added to the clients' accounts to ensure the clients had access to their bank accounts. Findings include: On 3/4/21 from 12:07 PM to 3:30 PM, an observation was conducted at the group home. During the observation at the group home, the following issues were noted: 1) Client F's hospital bed was slanted due to one of the four casters being broken off of the bed. The missing 5 inch caster made the bed slant to the side. One of client F's bedrails was bent and hanging over the side of his bed right above the broken caster. On 3/5/21 at 11:10 AM, the Area Director (AD) sent an email with a quote for a new bed for client F. The quote was dated 2/11/21. 2) Client F's light switch was broken and falling out of the wall in his bedroom on the living room side of the room. On 3/4/21 at 3:07 PM, the Program Director (PD) indicated client F's light switch needed to be repaired.		A second bid for the maintenance items listed in the survey and any other repairs that develop during repairs is in the process of being obtained and the home will be repaired once the contractor estimate is approved. Any future maintenance needs will be addressed timely following approval of estimates obtained for repairs. The wall in Client F's bedroom was painted before the survey exit was completed and if there are issues with this in the future, the wall will again be repainted timely. Staff in the home were retrained to monitor the water temperatures in the home on a regular basis for individuals' safety on 3/15/21. The temperatures have been obtained as required and are monitored and if the temperature increases about the required temperature, it will be immediately adjusted for health and safety. All individuals in the home except one are able to adjust their water temperature without assistance. Staff assist the other individual when he bathes/showers with adjusting his water temperature for his safety. Staff will continue to monitor the water temperatures weekly as required. Staff were retrained on following bed bug procedures at all times for health and safety of individuals in the home on 3/15/21. Treatments by an outside agency	

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	3) Client F's wall adjacent to the living room had writing covering a large portion of the wall. The writing said "Family Feud" over and over. 4) There were numerous garbage bags in the dining room of the group home. On 3/4/21 at 12:17 PM, staff #4 indicated the bags contained client A, B, C, D, E, F and G's clothes. Staff #4 indicated their clothes were bagged due to on-going issues with bed bugs at the home. Client D's bedroom floor had 3-4 garbage bags on the floor. On 3/4/21 at 12:22 PM, staff #8 told the surveyor to not use the handrail going up the stairs due to believing there were bed bugs living in the railing. Staff #8 indicated she saw bed bugs on the railing recently. Staff #8 indicated the home having bed bugs was an on-going issue at the group home. On 3/4/21 at 12:26 PM, staff #6 indicated bed bugs was an on-going issue at the group home. This affected clients A, B, C, D, E, F and G. The facility was initially cited for bed bugs on 12/13/16. The facility has had recurrent issues with bed bugs since 2016. 5) 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, the second floor hallway/landing, client C's bedroom and client G's bedroom. Client C's bedroom carpet had a one foot by one foot stained and discolored area in the middle of the room. Client G's bedroom had a 5 inch area in the carpet where the carpet was missing. The carpeting affected clients A, B, C, D, E, F and G. On 3/5/21 at 11:08 AM, a review of a 10/6/20 Proposal for work at the group home was conducted. The bid included replacing the carpet		continue to be completed and will be completed until the bed bugs are remedied from the home. Staff are to assist each individual with deep cleaning their bedrooms each month to decrease the risk of bed bugs being in the home. This along with the bid for the repairs in the home to replace the flooring on the stairs and bedrooms, possibly a new railing for the stairs and upstairs hallway, will assist with the eradication of the bed bugs in the home. All individuals' totes of clothing have been removed from the dining room of the home and are now back in their bedrooms and will continue to be hung up when laundry is completed along with keeping their bedrooms as clean as possible to prevent the spread of bed bugs. The bank has been contacted to correct the changes in the access of staff to assist the individuals with their banking. The individuals still have access to their money in their RFMS accounts and are able to spend money as they desire. The local accounts are in the process of being closed and all their money made available to them in their RFMS accounts as they desire so they can make purchases as needed. Until that time, Indiana MENTOR will continue to work with the local bank to ensure past staff are removed from the accounts and	

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	on the stairs. The bid did not include client C's and G's bedrooms. On 3/4/21 at 3:07 PM, the Program Director (PD) indicated the facility was obtaining bids for the carpeting. The PD indicated the carpeting needed to be replaced. 6) Client D's linoleum floor had a 3 foot by 3 foot area where the linoleum was torn and curled up. There was a section of the linoleum missing in the middle of the 3 foot by 3 foot tear. This affected clients A, B, C, D, E, F and G. On 3/5/21 at 11:08 AM, a review of a 10/6/20 Proposal for work at the group home was conducted. The bid included replacing the linoleum in client D's bedroom. 7) There were three holes in the upstairs hallway outside of client C's bedroom. The two holes were 4 inches by 4 inches. One hole close to the floor was 12 inches by 5 inches. This affected clients A, B, C, D, E, F and G. 8) Client A's bedroom wall had two-two inch holes in the wall. On 3/4/21 at 12:29 PM, the Area Director (AD) indicated she was working on getting bids to address the maintenance issues at the group home. The AD indicated the carpeting needed to be replaced. The AD indicated the holes needed to be repaired. The AD indicated client D's bedroom floor needed to be replaced. The AD indicated the home was routinely sprayed to address the bed bug issue. The AD indicated she was working on getting client F a new bed. 9) During the observation at the group home, the		current staff are added so the individuals have access to their money for any purchases they need/want to make. A weekly checklist will be completed by supervisory staff to observe items listed on this plan of correction are completed to ensure the home remains in good repair. Observations by supervisory staff will be completed at least 3 times per week for one month, twice a week for one month, weekly for one month and then at least monthly ongoing in the home to ensure the home is clean and in good repair, the water temperatures are being monitored and the beds are in good repair for health and safety. Persons Responsible: Program Supervisor, Program Director (QIDP), Area Director	

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	water temperature in the kitchen sink, bathroom sink and shower was 125 degrees Fahrenheit. The surveyor washed his hands in the kitchen sink and the water temperature was greater than 110 degrees Fahrenheit. The surveyor asked the staff to provide a thermometer to test the water temperature. The thermometer the facility provider was broken and did not work. The facility was unable to provide a working thermometer. The facility did not have a working thermometer to test the water temperature at the group home. This affected clients A, B, C, D, E, F and G. On 3/4/21 at 3:14 PM, the AD indicated the group home should have a working thermometer. 10) On 3/4/21 at 2:22 PM, a review of the clients' finances was conducted. Clients B, D, E and G's cash on hand did not match the money counted in the group home. During the review, it was discussed that clients A, B, C, D, E, F and G did not have access to the bank accounts due to the bank needing information from the facility in order to take the former PS off the clients' accounts and add the new PS to their accounts. On 3/8/21 at 1:52 PM, the Program Director (PD) stated the facility had been aware of the issue since November 2020. The PD indicated the former PS was working on it but did not get the situation addressed prior to leaving the company. The PD indicated the bank needed to have the signer of the account (former PS before the most recent PS) go into the bank and sign off on the accounts. The PD also needed a DBA (doing business as) form showing the facility changed its name from Transitional Services Inc. to Indiana Mentor. The PD indicated the issue had not been resolved and she was working on it.			

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	This federal tag relates to complaint #IN00347983. 9-3-1(a)			
W 0122 Bldg. 00	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview for 2 of 3 clients in the sample (A and C) and two additional clients (D and G), the facility failed to meet the Condition of Participation: Client Protections. The facility failed to implement its policies and procedures to prevent abuse, mistreatment and exploitation of the client, ensure staff immediately reported allegations of abuse to the administrator, ensure an incident was reported to the Bureau of Developmental Disabilities Services within 24 hours, and ensure appropriate corrective actions were implemented following an investigation to ensure the staff was not smoking marijuana and mistreating the clients. Findings include: 1) Please refer to W149. For 3 of 5 incident/investigative reports reviewed affecting client A, C, D and G, the facility failed to implement its policies and procedures to prevent abuse, mistreatment and exploitation of the client, ensure staff immediately reported allegations of abuse to the administrator, ensure an incident was reported to the Bureau of Developmental Disabilities Services within 24 hours, and ensure appropriate corrective actions were implemented following an investigation to ensure the staff was not smoking marijuana and	W 0122	Staff in the home were retrained on the prevention of abuse, neglect, exploitation and mistreatment, reporting incidents timely and following/implementing corrective actions as written on 3/15/21. The Program Director (QIDP) was retrained on 3/15/21 on submitting incident reports to BDDS timely and following developed corrective actions as written following investigations. The Program Director (QIDP) and Area Director will meet weekly for three months and then monthly ongoing to review that incident reports are submitted timely and that corrective actions are implemented as written. Persons Responsible: Program Supervisor, Program Director (QIDP), Area Director	04/08/2021

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	mistreating the clients. 2) Please refer to W153. For 2 of 5 incident/investigations reviewed affecting clients A and G, the facility failed to ensure staff immediately reported an allegation of abuse to the administrator and submitted an incident report to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law. 3) Please refer to W157. For 1 of 3 clients in the sample (A), the facility failed to ensure appropriate corrective action was taken following an allegation of abuse at the home. The facility failed to ensure administrative oversight of the group home included the staff involved in the allegation. This federal tag relates to complaint #IN00347983. 9-3-2(a)			
W 0140 Bldg. 00	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview for 4 of 7 clients living in the group home (B, D, E and G), the facility failed to keep an accurate accounting of the clients' funds. Findings include: On 3/4/21 at 2:22 PM, a review of the clients' finances was conducted. Clients B, D, E and G's cash on hand did not match the money counted in	W 0140	Staff in the home were retrained on 3/15/21 on accurately completing all finances for individuals anytime the individuals access their finances to ensure they have accurate amounts of money available to them at all times. All individuals' finances were reviewed and reconciled by the	04/08/2021

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	the group home. -Client B's February 2021 Daily Confirmation of Balance Record indicated his balance was $24.14. When the Program Supervisor (PS) counted client B's money, he had $0.65. There was $23.49 unaccounted for by the facility. -Client D's February 2021 Indiana Mentor Savings Account Record (being used for his cash on hand) indicated his balance was $5.00. When the PS looked, client D had no money. A 2/11/21 at 8:30 AM, a Money Counts sheet indicated, "[Client D] is off by $2.00." There was no documentation this was addressed by the facility. -Client E's January 2021 Cash on Hand Record indicated he had a balance of $42.08. When the PS counted client E's money, he had $67.77. Client E's balance was over by $25.69. There was no documentation indicating the facility addressed the issue. -Client G's January 2021 Cash on Hand Record indicated he had a balance of $4.54. When the PS counted client G's money, he had $13.64. Client G's balance was over by $9.10. There was no documentation indicating the facility addressed the issue. On 3/8/21 at 1:52 PM, the Program Director (PD) indicated the clients' money should be accounted for. On 3/8/21 at 3:55 PM, the Quality Improvement Specialist (QIS) indicated the facility should account for the clients' finances to the penny. The QIS stated the clients' money "should never be off."		Area Director following this survey. The discrepancy found during the survey was investigated during the survey, and a request for payment for Client G will be submitted for a discrepancy found of $14.86 unaccounted for in his finances to reimburse his account. The Program Supervisor and Program Director (QIDP) and one other staff in the home received financial training on 3/24/21. This training consists of how to ensure all individuals have the same financial forms, how to ensure accurate accounting on the financial forms at all times and to ensure all finances are completed and accurate to the penny for all individuals at all times. Moving forward, the PS, PD (QIDP) and one other staff in the home will be the only staff recording/monitoring the finances for all individuals. Other staff will assist the individuals with ensuring the individuals attend the activities to spend their money and will retain receipts and any monies they need/want to return to their cash on hand kept in the home so it can be monitored to the penny. The Program Director (QIDP) will monitor the individuals' finances at least weekly for accuracy and will immediately report to the Area Director any discrepancies found so an investigation can be completed and finances corrected	

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(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
	9-3-2(a)		immediately. The Program Director (QIDP) and Area Director will meet weekly for three months and then monthly ongoing to review that the individuals' finances are reconciled to the penny and there are no discrepancies or that an incident report and investigation has been completed to determine the cause of any discrepancy. Persons Responsible: Program Supervisor, Program Director (QIDP), Area Director	
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on interview and record review for 3 of 5 incident/investigative reports reviewed affecting client A, C, D and G, the facility failed to implement its policies and procedures to prevent abuse, mistreatment and exploitation of the client, ensure staff immediately reported allegations of abuse to the administrator, ensure an incident was reported to the Bureau of Developmental Disabilities Services within 24 hours, and ensure appropriate corrective actions were implemented following an investigation to ensure the staff was not smoking marijuana and mistreating the clients. Findings include: On 3/4/21 at 10:55 AM, a review of the facility's incident/investigative reports was conducted and indicated the following:	W 0149	Staff in the home were retrained on the prevention of abuse, neglect, exploitation and mistreatment, reporting incidents timely and following/implementing corrective actions as written on 3/15/21. The Program Director (QIDP) was retrained on 3/15/21 on submitting incident reports to BDDS timely and following developed corrective actions as written following investigations. The Program Director (QIDP) and Area Director will meet weekly for three months and then monthly ongoing to review that incident reports are submitted timely and that corrective actions are implemented as written.	04/08/2021

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	15G300	A. BUILDING 00 B. WING	03/09/2021

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	1) On 1/21/21, client A called the provider's office and alleged staff #4 called him a name and smoked marijuana in the group home van. The 1/21/21 Summary of Internal Investigation Report indicated, "...On 1/21/21 I went to the group home a few hours after the allegation to see how [client A] was doing. He was in good spirits and stated at the time he made the phone call he was upset with [staff #4] because [staff #4] did not take him out for an extra outing. [Client A] stated he was mad at the time and wanted to get [staff #4] in trouble. [Client A] did state that he had made the allegations up and that [staff #4] had not called him a name nor was he smoking marijuana in the company van. [Client A] stated that he was no longer mad at [staff #4] and they had made up... [Staff #4] did state that he does vape and when does vape (sic) it is in the designated smoking areas... [Staff #2] was interviewed via phone and he stated he was in the van with [staff #4] and [staff #4] was vaping and assumed or (sic) was a cartridge or vape with weed in it." The Conclusion of the investigation indicated, "Based on the information found during the investigation, and [client A] reporting he was upset with [staff #4], there isn't any evidence to substantiate the allegation as it was reported. [Staff #4] will receive corrective action for smoking in the van and all staff and individuals in the home will review the guideline of no tobacco in the vans. The PD (Program Director) will continue to monitor for appropriate interactions in the home between staff and individuals for health and safety." 2) On 2/23/21, Adult Protective Services contacted the Area Director to report she received an incident report alleging two staff (staff #4 and #6) at the group home smoke marijuana while working and one of the staff		Persons Responsible: Program Supervisor, Program Director (QIDP), Area Director	

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	(staff #4) was verbally, physically and emotionally abusive. The allegation included an allegation of staff #4 and client A getting into a physical fight and staff #4 calling client A a "stupid f------ idiot." The allegation indicated staff #4 left the home to go to his mom's house across the street from the group home to smoke marijuana. The allegation indicated staff #4 smoked marijuana in the group home using a vape. The allegation indicated a former staff was the only person on the clients' bank accounts therefore the former staff had to meet the clients at the bank in order for them to get money. The Conclusions of Fact section indicated, "The investigation did not substantiate the allegations made in the anonymous report of verbal, physical and emotional abuse by [staff #4] toward any individuals in the home. The investigation did not substantiate the allegations made in the anonymous report of [staff #6] and [staff #4] reporting to work 'high' and working that way during their work shift. The Program Director (QIDP/Qualified Intellectual Disabilities Professional) will complete unannounced observations at the home during the week to monitor interactions between staff and individuals." Following the investigation, the PD conducted observations at the group home on 2/23/21, 2/24/21, 2/25/21 and 3/4/21. There have been no observations conducted of staff #4 and staff #6 to ensure they were not reporting to work under the influence of marijuana. There were no unannounced observations conducted of staff #4 during his shifts to ensure his interactions with the clients were appropriate. On 3/8/21 at 2:14 PM, the PD indicated she			

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	conducted observations at the group home however none of the observations included staff #4 and #6. The PD indicated she would ensure she conducted observations at the group home when staff #4 and #6 were working. On 3/9/21 at 11:07 AM, the Quality Improvement Specialist stated "that would make sense the observations would have been conducted of them." On 3/9/21 at 11:18 AM, the Area Director indicated observations of staff #4 and #6 should have been conducted. 3) On 3/5/21 at 11:44 PM, the Area Director sent an email with a BDDS report attached. The report indicated, "On 3/4/21, during a complaint survey in the home by ISDH (Indiana State Department of Health), [client A] asked to speak with the surveyor and Area Director for Indiana MENTOR, and reported that on 2/27/21 and 2/28/21, a staff had come to his bedroom to get him up for morning med pass and dumped a bucket of ice water on his head to wake him up. [Client A] reported that this caused his bed to get wet as well. He reported that no other staff observed this incident, but other staff were in the home at the time. The staff reported to be involved (staff #4) was immediately suspended pending an investigation into the allegation. [Client A] reported he was not injured. No other individuals or staff have reported this type of behavior from this staff. An investigation is being conducted by the Quality Improvement Specialist. Supervisory staff will continue to monitor interactions between individuals and staff for safety. Staff will continue to follow [client A's] BSP which has a target behavior of making false allegations against staff. [Client A]			

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	reported he doesn't like this staff and doesn't like him working in the home. Recommendations from the investigation will be followed for the health and safety of all individuals in the home." On 3/4/21 at 12:35 PM, client A indicated staff #4 woke him up on 2/27/21 and 2/28/21 by pouring ice water on his head (client A showed the surveyor a picture on his phone of his wet bed). Client A indicated staff #4 continued to go across the street to his mom's house to smoke marijuana during his shifts. Client A stated, "I don't want to be here with him." Client A indicated staff #4 called him a name however he did not recall the name. Client A indicated he informed staff #1 and staff #5 on 3/1/21 of staff #4 pouring water on his head. Client A indicated staff #4 took client G's money to buy wings for everyone in the group home. Client A indicated on 3/3/21, staff #4 talked client C into buying wings for everyone at the group home. Client A stated, "Don't want to be here with him. He's getting out of control." Client A indicated staff #4 yelled at client D on 2/28/21 however client D did not report it. Client A stated, "[Staff #4] needs to be out of here." On 3/4/21 at 1:10 PM, client A indicated he reported the allegation to staff #1 on 2/28/21. On 3/8/21 at 5:07 PM, a review of the 3/8/21 investigation was conducted. The Incident Summary section indicated, "On 3/4/21, during a complaint survey in the home by ISDH, [client A] asked to speak with the surveyor and Area Director for Indiana MENTOR, and reported that on 2/27/21 and 2/28/21, a staff (staff #4) had come to his bedroom to get him up for morning med pass and dumped a bucket of ice water on his head to wake him up. [Client A] reported that this caused his bed to get wet as well. He			

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	reported that no other staff observed this incident, but other staff were in the home at the time. The staff reported to be involved was immediately suspended pending an investigation into the allegation. [Client A] reported he was not injured. No other individuals or staff have reported this type of behavior from this staff. An investigation is being conducted by the Quality Improvement Specialist. Supervisory staff will continue to monitor interactions between individuals and staff for safety. Staff will continue to follow [client A's] BSP which has a target behavior of making false allegations against staff. [Client A] reported he doesn't like this staff and doesn't like him working in the home. Recommendations from the investigation will be followed for the health and safety of all individuals in the home." The Conclusions of Fact section indicated, "Evidence supports that the allegation of [staff #4] pouring water on the head of [client A] is unsubstantiated." The investigation did not include recommendations. On 3/4/21 at 12:51 PM, client D stated he "can't remember" if staff #4 yelled at him or not on 2/28/21. On 3/4/21 at 1:00 PM, the Area Director (AD) indicated she suspended staff #4. The AD indicated staff #4 reported he had irritable bowel syndrome and had to go to his mom's house across the street in order to use the restroom during his shifts. On 3/4/21 at 1:17 PM, the AD indicated the former Program Supervisor was still on the clients' bank accounts. The AD indicated she was working on getting it resolved. On 3/4/21 at 1:04 PM, the Program Supervisor (PS) indicated she was aware of the allegation of client A having water dumped on his head on			

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	3/1/21. The PS indicated indicated she informed the PD on 3/1/21 of the allegation. The PS stated she "assumed it was reported to [AD]." The PS indicated staff #1 did not report the allegation to her on 2/28/21. The PS indicated she was aware staff #4 left the group home during his shifts for 30-45 minutes at a time to go across the street. The PS stated she was aware staff #4 "smelled like marijuana" at the start of his shifts. The PS stated, "Poor [client A]. Says nothing is being done." On 3/4/21 at 2:11 PM, the PS indicated client A sold his vape to staff #2. The PS stated this was "exploitation" of client A by staff #2. On 3/4/21 at 2:57 PM, the PS indicated she was aware of the allegations against staff #4. The PS indicated client A reported the allegation to her on 3/1/21. The PS indicated staff #5 also reported the allegation to her on 3/1/21. The PS, after checking her phone, indicated she texted the allegation to the PD on 3/1/21 at 8:07 PM. The PS indicated she did not report the allegation to the AD. On 3/4/21 at 1:39 PM, staff #6 indicated client G was missing $50.00 recently and client A had $50.00. She indicated she reported it to the Program Director. Staff #6 indicated staff #1 and staff #2 both shared their chewing tobacco with client A. She indicated this included staff #1 and #2 taking client A's chewing tobacco. On 3/4/21 at 1:39 PM, staff #8 indicated client G was missing $50.00 recently and client A had $50.00. On 3/4/21 at 2:10 PM, staff #5 stated "[staff #4] picks on [client A]. He bullies him. Raises his voice at him telling him what to do." On 3/4/21 at 2:12 PM, the PD indicated she			

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	heard client G was missing $50.00. The PD indicated it was not reported to BDDS. The PD indicated she had known about it for 2 days and should have reported it to BDDS within 24 hours. The PD indicated client A told her on 3/4/21 he sold his vape to staff #2 for $60.00. The PD stated "it's exploitation." The PD indicated she spoke to client A about staff #4 pouring water on him. Client A denied it happened. The PD indicated she told staff #4 to stay away from client A and to keep a second staff with him when he interacted with client A. The PD stated staff #1 and staff #2 taking/borrowing chewing tobacco from client A was "another example of exploitation." On 3/8/21 at 2:15 PM, the PD indicated the investigation was completed on 3/6/21. The PD indicated there was no evidence to verify staff #4 poured water on client A to wake him up. The PD indicated staff #4 returned to work on 3/7/21. On 3/5/21 at 10:39 AM, a review of client A's 12/29/19 Individualized Support Plan (ISP) indicated, "...List target behaviors and definition addressed in Behavior Support Plan: Aggression toward others, destructive to property, socially offensive behavior, uncooperative behavior, untrustworthy behavior, elopement, and inappropriate toileting...." Client A's 2/10/21 Behavior Support Plan (BSP) indicated, "... [Client A] is fully verbal and can communicate his wants and needs effectively...." The BSP indicated in the targeted behavior section, "...Untrustworthy behavior is defined as, but not limited to: Taking other's possessions and manipulating others to give him money, and lying and/or falsely accusing staff and peers." On 3/8/21 at 12:24 PM, the facility's Quality and Risk Management policy, dated April 2011, was			

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	reviewed. The policy indicated, in part, "Indiana Mentor promotes a high quality of service and seeks to protect individuals receiving Indiana Mentor services through oversight of management procedures and company operations, close monitoring of service delivery and through a process of identifying evaluating and reducing risk to which individuals are exposed...." The April 2011 Human Rights policy indicated, in part, "The following actions are prohibited by employees of Indiana MENTOR: abuse, neglect, exploitation or mistreatment of an individual including misuse of an individual's funds; or violation of an individual's rights." This federal tag relates to complaint #IN00347983. 9-3-2(a)			
W 0153 Bldg. 00	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 2 of 5 incident/investigations reviewed affecting clients A and G, the facility failed to ensure staff immediately reported an allegation of abuse to the administrator and submitted an incident report to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law. Findings include:	W 0153	Staff in the home were retrained on the prevention of abuse, neglect, exploitation and mistreatment, reporting incidents timely and following/implementing corrective actions as written on 3/15/21. The Program Director (QIDP) was retrained on 3/15/21 on submitting incident reports to BDDS timely and following developed corrective	04/08/2021

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	On 3/4/21 at 10:55 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 3/5/21 at 11:44 PM, the Area Director sent an email with a BDDS report attached. The report indicated, "On 3/4/21, during a complaint survey in the home by ISDH (Indiana State Department of Health), [client A] asked to speak with the surveyor and Area Director for Indiana MENTOR, and reported that on 2/27/21 and 2/28/21, a staff had come to his bedroom to get him up for morning med pass and dumped a bucket of ice water on his head to wake him up. [Client A] reported that this caused his bed to get wet as well. He reported that no other staff observed this incident, but other staff were in the home at the time. The staff reported to be involved (staff #4) was immediately suspended pending an investigation into the allegation. [Client A] reported he was not injured. No other individuals or staff have reported this type of behavior from this staff. An investigation is being conducted by the Quality Improvement Specialist. Supervisory staff will continue to monitor interactions between individuals and staff for safety. Staff will continue to follow [client A's] BSP which has a target behavior of making false allegations against staff. [Client A] reported he doesn't like this staff and doesn't like him working in the home. Recommendations from the investigation will be followed for the health and safety of all individuals in the home." On 3/4/21 at 12:35 PM, client A indicated staff #4 woke him up on 2/27/21 and 2/28/21 by pouring ice water on his head (client A showed the surveyor a picture on his phone of his wet bed). Client A indicated he informed staff #1 and staff #5 on 3/1/21 of staff #4 pouring water		actions as written following investigations. The Program Director (QIDP) and Area Director will meet weekly for three months and then monthly ongoing to review that incident reports are submitted timely and that corrective actions are implemented as written. Persons Responsible: Program Supervisor, Program Director (QIDP), Area Director	

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	on his head. On 3/4/21 at 1:10 PM, client A indicated he reported the allegation to staff #1 on 2/28/21. On 3/4/21 at 1:04 PM, the Program Supervisor (PS) indicated she was aware of the allegation of client A having water dumped on his on 3/1/21. The PS indicated indicated she informed the PD on 3/1/21 of the allegation. The PS stated she "assumed it was reported to [AD]." The PS indicated staff #1 did not report the allegation to her on 2/28/21. On 3/4/21 at 2:57 PM, the PS indicated she was aware of the allegations against staff #4. The PS indicated client A reported the allegation to her on 3/1/21. The PS indicated staff #5 also reported the allegation to her on 3/1/21. The PS, after checking her phone, indicated she texted the allegation to the PD on 3/1/21 at 8:07 PM. The PS indicated she did not report the allegation to the Area Director. On 3/8/21 at 3:37 PM, the Quality Improvement Specialist (QIS) indicated the staff should immediately report allegations of abuse, neglect, exploitation and mistreatment to the administrator. The QIS indicated the timeframe for reporting incidents to BDDS was 24 hours. 2) A 3/5/21 BDDS report indicated on 3/4/21 at 12:45 PM, "...during a complaint survey by ISDH (Indiana State Department of Health), a report was made that [client G] was missing $50 from his cash on hand in the home. An investigation was immediately started and continues but a preliminary review of his finances shows a discrepancy of $14.86 from what is documented on his cash on hand record and what money is available...." On 3/4/21 at 2:22 PM, a review of the clients'			

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	finances was conducted. Client G's January 2021 Cash on Hand Record indicated he had a balance of $4.54. When the PS counted client G's money, he had $13.64. Client G's balance was over by $9.10. On 3/4/21 at 1:39 PM, staff #6 indicated client G was missing $50.00 recently and client A had $50.00. She indicated she reported it to the Program Director. On 3/4/21 at 1:39 PM, staff #8 indicated client G was missing $50.00 recently and client A had $50.00. On 3/4/21 at 2:12 PM, the Program Director (PD) indicated she heard client G was missing $50.00. The PD indicated it was not reported to BDDS. The PD indicated she had known about it for 2 days and should have reported it to BDDS within 24 hours. On 3/8/21 at 3:55 PM, the Quality Improvement Specialist (QIS) indicated incidents should be reported to BDDS within 24 hours. 9-3-2(a)			
W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 1 of 3 clients in the sample (A), the facility failed to ensure appropriate corrective action was taken following an allegation of abuse at the home. The facility failed to ensure administrative oversight of the group home included the staff involved in the allegation.	W 0157	Staff in the home were retrained on the prevention of abuse, neglect, exploitation and mistreatment, reporting incidents timely and following/implementing corrective actions as written on 3/15/21. The Program Director (QIDP) was	04/08/2021

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	Findings include: On 3/4/21 at 10:55 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 2/23/21, Adult Protective Services contacted the Area Director to report she received an incident report alleging two staff (staff #4 and #6) at the group home smoke marijuana while working and one of the staff (staff #4) was verbally, physically and emotionally abusive. The allegation included an allegation of staff #4 and client A getting into a physical fight and staff #4 calling client A a "stupid f------ idiot." The allegation indicated staff #4 left the home to go to his mom's house across the street from the group home to smoke marijuana. The allegation indicated staff #4 smoked marijuana in the group home using a vape. The allegation indicated a former staff was the only person on the clients' bank accounts therefore the former staff had to meet the clients at the bank in order for them to get money. The Conclusions of Fact section indicated, "The investigation did not substantiate the allegations made in the anonymous report of verbal, physical and emotional abuse by [staff #4] toward any individuals in the home. The investigation did not substantiate the allegations made in the anonymous report of [staff #6] and [staff #4] reporting to work 'high' and working that way during their work shift. The Program Director (QIDP/Qualified Intellectual Disabilities Professional) will complete unannounced observations at the home during the week to monitor interactions between staff and individuals."		retrained on 3/15/21 on submitting incident reports to BDDS timely and following developed corrective actions as written following investigations. The Program Director (QIDP) and Area Director will meet weekly for three months and then monthly ongoing to review that incident reports are submitted timely and that corrective actions are implemented as written. Persons Responsible: Program Supervisor, Program Director (QIDP), Area Director	

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	15G300	A. BUILDING 00 B. WING	03/09/2021

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	Following the investigation, there have been no observations conducted of staff #4 and staff #6 to ensure they were not reporting to work under the influence of marijuana. There were no unannounced observations conducted of staff #4 during his shifts. On 3/8/21 at 2:14 PM, the PD indicated she conducted observations at the group home however none of the observations included staff #4 and #6. The PD indicated she would ensure she conducted observations at the group home when staff #4 and #6 were working. On 3/9/21 at 11:07 AM, the Quality Improvement Specialist stated "that would make sense the observations would have been conducted of them." On 3/9/21 at 11:18 AM, the Area Director indicated observations of staff #4 and #6 should have been conducted. This federal tag relates to complaint #IN00347983. 9-3-2(a)			
W 0227 Bldg. 00	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, interview and record review for 1 of 4 non-sampled clients (F), the facility failed to ensure client F had a plan for securing pens in the group home to prevent him from writing on his bedroom wall.	W 0227	Client F's team is in the process of scheduling a meeting and this meeting will address making updates to his program plan for securing pens following their use	04/08/2021

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	Findings include: On 3/4/21 from 12:07 PM to 3:30 PM, an observation was conducted at the group home. During the observation, client F's wall adjacent to the living room had writing covering a large portion of the wall. The writing said "Family Feud" over and over. On 3/5/21 at 9:56 AM, a review of client F's plans was conducted. Client F's 2/21/20 Individualized Support Plan (ISP) and 10/2/20 Behavior Support Plan (BSP) did not address client F's behavior of writing on his walls. On 3/8/21 at 3:02 PM, the Program Director (PD) indicated she thought client F's ISP and BSP addressed securing pens and markers due to client F's history of writing on walls in his bedroom. The PD stated "I thought it was in there... He needs a plan." The PD indicated staff was trained to put up pens and markers to ensure he did not have access to them due to his history of writing on walls. 9-3-4(a)		in the home to prevent him from writing on his bedroom walls or other walls in the home. The wall in Client F's bedroom was painted before the survey exit was completed and if there are issues with this in the future, the wall will again be repainted timely. A weekly checklist will be completed by supervisory staff to observe items listed on this plan of correction are completed to ensure the home remains in good repair. Persons Responsible: Program Supervisor, Program Director (QIDP), Area Director	
W 0426 Bldg. 00	483.470(d)(3) CLIENT BATHROOMS The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit. Based on observation, interview and record review for 7 of 7 clients living in the group home (A, B, C, D, E, F and G), the facility failed to ensure the water temperature did not exceed 110	W 0426	Staff in the home were retrained to monitor the water temperatures in the home on a regular basis for individuals' safety on 3/15/21.	04/08/2021

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	degrees Fahrenheit. Findings include: On 3/4/21 from 12:07 PM to 3:30 PM, an observation was conducted at the group home. During the observation at the group home, the water temperature in the kitchen sink, bathroom sink and shower was 125 degrees Fahrenheit. The surveyor washed his hands in the kitchen sink and the water temperature was greater than 110 degrees Fahrenheit. The surveyor asked the staff to provide a thermometer to test the water temperature. The thermometer the facility provider was broken and did not work. The facility was unable to provide a working thermometer. The facility did not have a working thermometer to test the water temperature at the group home. This affected clients A, B, C, D, E, F and G. On 3/8/21 at 3:12 PM, a review of the facility's Water Temperature documentation from February 2021 and March 2021 was conducted. The facility did not test the water temperature in February and March 2021 prior to the surveyor testing the water temperature. The bottom of the Water Temperature form indicated, "If the water temperature exceeds 110 degrees Fahrenheit, it needs to be adjusted. If it cannot be immediately adjusted, staff must directly supervise all individuals who cannot independently adjust water temperature. Notify your supervisor immediately if temperature exceeds 120 degrees Fahrenheit. The supervisor will ensure that water temperature is adjusted." On 3/4/21 at 3:14 PM, the Area Director indicated the water temperature should not exceed 110 degrees Fahrenheit.		The temperatures have been obtained as required and are monitored and if the temperature increases about the required temperature, it will be immediately adjusted for health and safety. All individuals in the home except one are able to adjust their water temperature without assistance. Staff assist the other individual when he bathes/showers with adjusting his water temperature for his safety. Staff will continue to monitor the water temperatures weekly as required. A weekly checklist will be completed by supervisory staff to observe items listed on this plan of correction are completed to ensure the water temperatures are maintained at required temperatures for safety. Persons Responsible: Program Supervisor, Program Director (QIDP), Area Director	

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	9-3-7(a)			
W 0455 Bldg. 00	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation and interview for 7 of 7 clients living in the group home (A, B, C, D, E, F and G), the facility failed to ensure there was soap in the downstairs bathroom in order to promote handwashing during a global pandemic due to Covid-19. Findings include: On 3/4/21 from 12:07 PM to 3:30 PM, an observation was conducted at the group home. During the observation at the group home, there was no soap in the bathroom on the second floor of the group home. This affected clients A, B, C, D, E, F and G. On 3/4/21 at 3:10 PM, the Area Director indicated there should be soap in the bathroom. On 3/4/21 at 3:10 PM, the Program Director indicated there should be soap in the bathroom. 9-3-7(a)	W 0455	Staff in the home were retrained on COVID-19 cleaning procedures on all shifts including ensuring all bathrooms and the kitchen have hand soap available for use at all times on 3/15/21. A weekly checklist will be completed by supervisory staff to observe items listed on this plan of correction are completed to ensure soap is in the bathrooms and kitchen at all times for use for the health and safety of all individuals' and staff. Persons Responsible: Program Supervisor, Program Director (QIDP), Area Director	04/08/2021