STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u>		COMPL	COMPLETED	
		15G300	B. WI	B. WING		03/09/	03/09/2021	
		l .		STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER	R						
TRANSIT	ONAL SERVICES	SUB LLC	110 W PIKE ST MARTINSVILLE, IN 46151					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY 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	
W 0000								
Bldg. 00	#IN00347983. Thi focused infection co Complaint #IN0034 Federal and state do	47983 - Substantiated. eficiencies related to the cited at W102, W104, W122,	W 0	000				
	Survey dates: Marc Facility Number: 0 Provider Number: 1	00819 15G300						
	accordance with 46	this report completed by						
W 0102	483.410							
Bldg. 00	The facility must egoverning body are requirements are Based on observation interview for 7 of 7 home (A, B, C, D, I to meet the Condition Governing Body. Tailed to exercise of	met. on, record review and clients living in the group E, F and G), the facility failed on of Participation: The facility's governing body perating direction over the	W 0	102	Staff in the home were retrained on the prevention of abuse, neglect, exploitation and mistreatment, reporting incident timely and following/implement corrective actions as written of 3/15/21.	nts ting	04/08/2021	
	from abuse, neglect exploitation. The g	o ensure the clients were free t, mistreatment and governing body failed to iately reported allegations of			A second bid for the maintena items listed in the survey and a other repairs that develop duri	any		

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

TITLE

000819

(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.

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	OF CORRECTION  IDENTIFICATION NUMBER:  15G300	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 03/09/2021	
	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	
	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 bei obtained and the home will be repaired once the contractor estimate is approved. Any fut maintenance needs will be addressed timely following approval of estimates obtained repairs.  Staff in the home were retrained to monitor the water temperate in the home on a regular basis individuals' safety on 3/15/21. The temperatures have been obtained as required and are monitored and if the temperate increases about the required temperature, it will be immediated adjusted for health and safety individuals in the home except 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 temperature weekly as required.  Staff were retrained on following bed bug procedures at all time for health and safety of individing in the home on 3/15/21.  Treatments by an outside age continue to be completed and be completed until the bed bug are remedied from the home. Staff are to assist each individing with deep cleaning their bedroeach month to decrease the rifully of bed bugs being in the home. This along with the bid for the	ure  d for ed ures s for  ure  ately All cone e. I re ue ures ng es uals ncy will gs ual oms sk	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
		15G300	B. WING		03/09/2021		
N	DOLUBER OF STREET	<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP CODE	•		
NAME OF P	NAME OF PROVIDER OR SUPPLIER			PIKE ST			
TRANSIT	IONAL SERVICES	SUB LLC		INSVILLE, IN 46151			
				· · · · · · · · · · · · · · · · · · ·	(V5)		
(X4) ID PREFIX		CV MUST BE DESCRIBED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION		
	•	CY MUST BE PRECEDED BY FULL		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE COMPLETION		
TAG		LSC IDENTIFYING INFORMATION)	TAG				
		a current staff added to the		repairs in the home to replace	e tne		
		ensure the clients had access		flooring on the stairs and	11:		
	to their bank accour	its.		bedrooms, possibly a new railing			
	0) P1	1100 F 0 C2 I' . '		for the stairs and upstairs ha	-		
	· ·	V122. For 2 of 3 clients in		will assist with the eradicatio			
		C) and two additional clients		the bed bugs in the home. All			
		rning body failed to meet the		individuals' totes of clothing I			
		pation: Client Protections.		been removed from the dinin	-		
	The facility's governing body failed to implement			room of the home and are no			
	its policies and procedures to prevent abuse,			back in their bedrooms and v			
mistreatment and exploitation of the client,				continue to be hung up wher			
ensure staff immediately reported allegations of				laundry is completed along w			
	abuse to the administrator, ensure an incident			keeping their bedrooms as c			
	_	Bureau of Developmental		as possible to prevent the sp	read		
	Disabilities Services within 24 hours, and ensure			of bed bugs.			
		ve actions were implemented		A quote for Client F's bed ha			
	_	gation to ensure the staff was		already been obtained prior t			
		ana and mistreating the		survey. The bed has now been			
	clients.			purchased and delivered to t			
				home. The new bed was deli			
	This federal tag rela	ites to complaint		on 3/24/21. The old bed has			
	#IN00347983.			discarded. The bed will mon			
				and will be replaced timely if	it		
	9-3-1(a)			becomes in poor repair.			
				The bank has been contacte			
				correct the changes in the ac			
				of staff to assist the individua			
				with their banking. The indivi			
				still have access to their mor	-		
				their RFMS accounts and are			
				to spend money as they desi			
				The local accounts are in the			
				process of being closed and			
				their money made available			
				them in their RFMS accounts			
				they desire so they can make			
				purchases as needed. Until	that		
				time, Indiana MENTOR will			
				continue to work with the loc	al		
				bank to ensure past staff are			
l l			I	I	I		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC A. BUILDING	00	(X3) DATE SURVEY  COMPLETED			
	or condition.	15G300	B. WING	00	03/09/2021		
	PROVIDER OR SUPPLIEF	2	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)	(X5) COMPLETION DATE		
				removed from the accounts are current staff are added so the individuals have access to the money for any purchases they need/want to make.  A weekly checklist will be completed by supervisory staff observe items listed on this placorrection are completed to ensure the home remains in grepair.  Observations by supervisory swill be completed at least 3 timper week for one month, twice week for one month, weekly for one month and then at least monthly ongoing in the home to ensure the home is clean and good repair, the water temperatures are being monitor and the beds are in good repair for health and safety.  Persons Responsible: Progra Supervisor, Program Director (QIDP), Area Director	f to an of  ood  taff nes a or o in		
W 0104 Bldg. 00	policy, budget, an	DY dy must exercise general d operating direction over					
	interview for 7 of 7 home (A, B, C, D, I governing body fail direction over the fa client F's bed remai F's light switch was client F's bedroom	on, record review and clients living in the group E, F and G), the facility's ed to exercise operating acility by failing to ensure: 1) ned in good repair, 2) client not falling out of the wall, 3) wall did not have writing on f took steps to address	W 0104	A quote for Client F's bed had already been obtained prior to survey. The bed has now bee purchased and delivered to the home. The new bed was delive on 3/24/21. The old bed has b discarded. The bed will monit and will be replaced timely if it becomes in poor repair.	n e ered een ored		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED			
		15G300	B. W	B. WING			03/09/2021	
				OTTO FEET	ADDRESS OF A STATE OF SORE			
NAME OF F	PROVIDER OR SUPPLIER	<b>t</b>			ADDRESS, CITY, STATE, ZIP CODE			
					PIKE ST			
TRANSII	TIONAL SERVICES	SUB LLC		MARII	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 APPROPRIAT	TE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE	
	on-going issues with bed bugs in the group home,				A second bid for the maintena	nce		
	5) the carpeting in t	he group home was replaced			items listed in the survey and a	any		
	due to being discolo	ored, frayed and stained, 6)			other repairs that develop duri	ng		
	client D's linoleum	floor was free of tears and			repairs is in the process of bei	ng		
	holes, 7) the upstair	s hallway was free of holes,			obtained and the home will be			
	8) client A's bedroo	m walls did not have holes in			repaired once the contractor			
	it, 9) there was a working thermometer in the				estimate is approved. Any fut	ure		
	group home to test the water temperature, and				maintenance needs will be			
	10) the former Program Supervisor (PS) was				addressed timely following			
	removed from the clients' bank accounts and a				approval of estimates obtained	d for		
	current staff added to the clients' accounts to				repairs. The wall in Client F's			
	ensure the clients had access to their bank				bedroom was painted before the			
	accounts.				survey exit was completed and	d if		
					there are issues with this in the	9		
	Findings include:				future, the wall will again be			
					repainted timely.			
		07 PM to 3:30 PM, an			Staff in the home were retrained			
		nducted at the group home.		to monitor the water temperatures				
	_	tion at the group home, the			in the home on a regular basis	for		
	following issues we	ere noted:			individuals' safety on 3/15/21.			
					The temperatures have been			
		al bed was slanted due to one			obtained as required and are			
		being broken off of the bed.			monitored and if the temperatu	ıre		
		caster made the bed slant to			increases about the required			
		ent F's bedrails was bent and			temperature, it will be immedia	-		
		de of his bed right above the			adjusted for health and safety.			
	broken caster.				individuals in the home except	one		
	0.0/5/01 . 11.10	116 d			are able to adjust their water			
		AM, the Area Director (AD)			temperature without assistance			
		a quote for a new bed for			Staff assist the other individua	I		
	client F. The quote	was dated 2/11/21.			when he bathes/showers with			
	2) Cliant El-1:-1:	writch was hadron s. J. C.II			adjusting his water temperatur			
		witch was broken and falling s bedroom on the living room			for his safety. Staff will continu			
	side of the room.	s begroom on the fiving room			to monitor the water temperatu	11 <del>C</del> S		
	side of the room.				weekly as required.	20		
	On 3/4/21 at 2.07 D	M, the Program Director			Staff were retrained on following bed bug procedures at all time	-		
		nt F's light switch needed to			for health and safety of individ			
	be repaired.	n 1 5 fight switch needed to			in the home on 3/15/21.	uais		
	be repaired.					acv.		
			1		Treatments by an outside age	icy		

	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G300	ľ í	ILDING	instruction 00	(X3) DATE : COMPL 03/09/	ETED
	PROVIDER 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 APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
TAG	3) Client F's wall as writing covering a lawriting said "Family"  4) There were numdining room of the game of the	djacent to the living room had arge portion of the wall. The y Feud" over and over.  erous garbage bags in the group home. On 3/4/21 at ndicated the bags contained a F and G's clothes. Staff #4 es were bagged due to a bed bugs at the home. floor had 3-4 garbage bags 1/21 at 12:22 PM, staff #8 not use the handrail going up eving there were bed bugs Staff #8 indicated she saw ing recently. Staff #8 having bed bugs was an e group home. On 3/4/21 at ndicated bed bugs was an e group home. This affected E, F and G.		TAG	continue to be completed and be completed until the bed bug are remedied from the home. Staff are to assist each individing with deep cleaning their bedroeach month to decrease the rise of bed bugs being in the home. This along with the bid for the repairs in the home to replace flooring on the stairs and bedrooms, possibly a new railing for the stairs and upstairs hallow will assist with the eradication the bed bugs in the home. All individuals' totes of clothing has been removed from the dining room of the home and are now back in their bedrooms and with continue to be hung up when laundry is completed along with keeping their bedrooms as cleas possible to prevent the spreof bed bugs.  The bank has been contacted correct the changes in the accordistiff to assist the individuals with their banking. The individuals with their banking. The individuals with their banking. The individuals with their banking accounts and are at to spend money as they desire to spend money as they desire to spend money as they desire to spend make available to them in their RFMS accounts at they desire so they can make purchases as needed. Until the time, Indiana MENTOR will continue to work with the local bank to ensure past staff are removed from the accounts and re	will gs ual oms sk the ng vay, of l h an ead to ess uals y in able	DATE

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLE	TED
		15G300	B. WING 03/09/2021		2021		
			<u> </u>	CTREET 4	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			1			
<b>TD 4 1 10 1</b>					PIKE ST		
IRANSII	TIONAL SERVICES	SUB LLC		MARIII	NSVILLE, IN 46151		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	DROVIDED'S DI 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 APPROPRIA	T-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	.16	DATE
	on the stairs. The b	id did not include client C's			current staff are added so the		
	and G's bedrooms.				individuals have access to the	ir	
					money for any purchases they	l l	
	On 3/4/21 at 3:07 P	M, the Program Director			need/want to make.		
		acility was obtaining bids for			A weekly checklist will be		
	1 1	PD indicated the carpeting			completed by supervisory staf	f to	
	needed to be replace				observe items listed on this pla	I .	
	·				correction are completed to		
	6) Client D's linole	um floor had a 3 foot by 3			ensure the home remains in g	ood	
		linoleum was torn and curled			repair.		
	up. There was a section of the linoleum missing				Observations by supervisory s	staff	
in the middle of the 3 foot by 3 foot tear. This					will be completed at least 3 tin	I .	
affected clients A, B, C, D, E, F and G.				per week for one month, twice			
					week for one month, weekly for	I .	
	On 3/5/21 at 11:08	AM, a review of a 10/6/20			one month and then at least		
		t the group home was			monthly ongoing in the home	to	
	_	included replacing the			ensure the home is clean and		
	linoleum in client D				good repair, the water		
					temperatures are being monitor	ored	
	7) There were three	e holes in the upstairs hallway			and the beds are in good repa	iir	
	outside of client C's	bedroom. The two holes			for health and safety.		
	were 4 inches by 4 i	inches. One hole close to the			Persons Responsible: Progra	m	
	floor was 12 inches	by 5 inches. This affected			Supervisor, Program Director		
	clients A, B, C, D, I	E, F and G.			(QIDP), Area Director		
	8) Client A's bedro	om wall had two-two inch					
	holes in the wall.						
	On 3/4/21 at 12:29 l	PM, the Area Director (AD)					
	indicated she was w	orking on getting bids to					
	address the mainten	ance issues at the group					
	home. The AD indi	icated the carpeting needed to					
	be replaced. The A	D indicated the holes needed					
		AD indicated client D's					
	bedroom floor need	ed to be replaced. The AD					
		was routinely sprayed to					
	address the bed bug	issue. The AD indicated she					
	was working on get	ting client F a new bed.					
	9) During the observation at the group home, the						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	ULTIPLE CO. JILDING	NSTRUCTION 00	(X3) DATE COMPL		
		15G300	B. W		<u>00</u>	03/09/	
	PROVIDER OR SUPPLIER		<u> </u>	110 W F	DDRESS, CITY, STATE, ZIP CODE PIKE ST NSVILLE, IN 46151		
	SUMMARY S' (EACH DEFICIEN REGULATORY OR  water temperature in sink and shower was the surveyor washe and the water temperature. The figure of the provide a thermous temperature. The figure of the provider was broken facility was unabled thermometer. The figure of the facility was unabled the mometer to test group home. This as F and G.  On 3/4/21 at 3:14 P group home should  10) On 3/4/21 at 2: clients' finances was and G's cash on han counted in the group was discussed that of did not have access the bank needing in order to take the for accounts and add the On 3/8/21 at 1:52 P (PD) stated the facility of the summary of the facility of the facil			110 W F	PIKE ST	TE.	(X5) COMPLETION DATE
	the situation address company. The PD is have the signer of the the most recent PS) on the accounts. The (doing business as) changed its name for to Indiana Mentor.	working on it but did not get sed prior to leaving the indicated the bank needed to be account (former PS before go into the bank and sign off the PD also needed a DBA form showing the facility form Transitional Services Inc.  The PD indicated the issue ed and she was working on it.					
		-					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G300		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  03/09/2021				
TRANSI	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)	(X5) COMPLETION DATE			
	This federal tag rela#IN00347983.	ates to complaint						
W 0122	483.420	TIONS						
Bldg. 00	protections require Based on record rev clients in the sample additional clients (I meet the Condition Protections. The fa policies and proced mistreatment and ex ensure staff immedi abuse to the admini was reported to the Disabilities Service appropriate correcti following an investi	ensure that specific client	W 0122	Staff in the home were retrained on the prevention of abuse, neglect, exploitation and mistreatment, reporting incident timely and following/implement corrective actions as written of 3/15/21.  The Program Director (QIDP) retrained on 3/15/21 on submit incident reports to BDDS timel and following developed correlactions as written following investigations.  The Program Director (QIDP) Area Director will meet weekly three months and then monthly ongoing to review that incidents.	nts ting n was tting y ctive and for			
	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			reports are submitted timely and that corrective actions are implemented as written.  Persons Responsible: Program Supervisor, Program Director (QIDP), Area Director	nd			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G300		A. BUILDING  B. WING	00	COMPLETED 03/09/2021			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  110 W PIKE ST  MARTINSVILLE, IN 46151				
TRANSIT (X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENCE REGULATORY OR mistreating the clience 2) Please refer to Wincident/investigation A and G, the facility immediately reported the administrator and report to the Bureau	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) Its.  7153. For 2 of 5 ons reviewed affecting clients of failed to ensure staff d an allegation of abuse to d submitted an incident of Developmental s (BDDS) within 24 hours, in	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE		
	the sample (A), the appropriate corrective following an allegate. The facility failed to	ion of abuse at the home.  ensure administrative  p home included the staff pation.					
W 0140 Bldg. 00	system that assure accounting of clien entrusted to the far Based on record rev clients living in the action of the clients' funds.  Findings include:  On 3/4/21 at 2:22 Pt finances was conductive.	establish and maintain a ses a full and complete sets' personal funds cility on behalf of clients. siew and interview for 4 of 7 group home (B, D, E and G), keep an accurate accounting	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	uals e f		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED	
		15G300	B. Wl	NG		03/09/	/2021
				STREET /	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			PIKE ST		
TDANGI	TIONAL SERVICES	SUBILC			NSVILLE, IN 46151		
TRANSITIONAL SERVICES SUB LLC			WARTH	NOVIELE, IN 40151			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY 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
	the group home.				Area Director following this		
					survey. The discrepancy four		
	-Client B's February 2021 Daily Confirmation of				during the survey was investig	-	
		licated his balance was			during the survey, and a requ		
		Program Supervisor (PS)			for payment for Client G will b		
		noney, he had \$0.65. There			submitted for a discrepancy for		
	was \$23.49 unaccounted for by the facility.				of \$14.86 unaccounted for in I	าเร	
	-Client D's February 2021 Indiana Mentor				finances to reimburse his		
					account.		
	Savings Account Record (being used for his cash on hand) indicated his balance was \$5.00. When				The Program Supervisor and	000	
	the PS looked, client D had no money. A				Program Director (QIDP) and other staff in the home receive		
	-				financial training on 3/24/21.		
	2/11/21 at 8:30 AM, a Money Counts sheet indicated, "[Client D] is off by \$2.00." There was				training consists of how to ens		
	_	his was addressed by the			all individuals have the same	suie	
	facility.	ms was addressed by the			financial forms, how to ensure	,	
	lacility.				accurate accounting on the	•	
	-Client F's Ianuary	2021 Cash on Hand Record			financial forms at all times and	d to	
		palance of \$42.08. When the			ensure all finances are comple		
		strainee of \$12.00. When the			and accurate to the penny for		
		vas over by \$25.69. There			individuals at all times. Movin		
		ion indicating the facility			forward, the PS, PD (QIDP) a	•	
	addressed the issue	-			one other staff in the home wi		
					the only staff recording/monito		
	-Client G's January	2021 Cash on Hand Record		the finances for all individuals.			
		palance of \$4.54. When the		Other staff will assist the			
	PS counted client C	d's money, he had \$13.64.		individuals with ensu			
	Client G's balance v	was over by \$9.10. There was		individuals attend t		s to	
	no documentation i	ndicating the facility			spend their money and will re	tain	
	addressed the issue				receipts and any monies they		
					need/want to return to their ca	ısh	
		M, the Program Director			on hand kept in the home so i		
	1 1	clients' money should be			can be monitored to the penny	-	
	accounted for.				The Program Director (QIDP)		
					monitor the individuals' financ		
		M, the Quality Improvement			least weekly for accuracy and		
		licated the facility should			immediately report to the Area		
		nts' finances to the penny.			Director any discrepancies for	und	
	1	clients' money "should never			so an investigation can be		
	be off."				completed and finances corre	cted	

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	AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  15G300		A. BUILDING  B. WING	00	COMPLETED 03/09/2021		
	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
W 0149	9-3-2(a) 483.420(d)(1)			immediately. The Program Director (QIDP) Area Director will meet weekly three months and then monthl ongoing to review that the individuals' finances are reconciled to the penny and th are no discrepancies or that a incident report and investigation has been completed to determ the cause of any discrepancy. Persons Responsible: Progra Supervisor, Program Director (QIDP), Area Director	r for y nere n on nine		
Bldg. 00	STAFF TREATME The facility must d written policies and mistreatment, negl Based on interview incident/investigativ client A, C, D and C implement its polici abuse, mistreatment client, ensure staff in allegations of abuse an incident was repo Developmental Disa hours, and ensure ap were implemented f ensure the staff was mistreating the client Findings include:  On 3/4/21 at 10:55 a	evelop and implement d procedures that prohibit lect or abuse of the client. and record review for 3 of 5 ve reports reviewed affecting G, the facility failed to es and procedures to prevent and exploitation of the mmediately reported to the administrator, ensure orted to the Bureau of abilities Services within 24 propriate corrective actions following an investigation to not smoking marijuana and ats.  AM, a review of the facility's ve reports was conducted and	W 0149	Staff in the home were retrained on the prevention of abuse, neglect, exploitation and mistreatment, reporting incide timely and following/implement corrective actions as written of 3/15/21.  The Program Director (QIDP) retrained on 3/15/21 on submit incident reports to BDDS time and following developed corrections as written following investigations.  The Program Director (QIDP) Area Director will meet weekly three months and then monthly ongoing to review that incident reports are submitted timely at that corrective actions are implemented as written.	nts ting n was tting ly ctive and for		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G300	l í	JILDING	onstruction 00	(X3) DATE : COMPL 03/09/	ETED
NAME OF I	PROVIDER OR SUPPLIER		•	110 W F	ADDRESS, CITY, STATE, ZIP CODE		
TRANSI	TIONAL SERVICES	SUB LLC		MARTIN	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
TAG	1) On 1/21/21, clies office and alleged sismoked marijuana in 1/21/21 Summary on Report indicated, " group home a few hasee how [client A] was pirits and stated at call he was upset with a state that he had man and they had made the does vape and with designated smoking interviewed via phowan with [staff #4] a assumed or (sic) was weed in it." The Coindicated, "Based or during the investigate he was upset with [staff #4] action for smoking individuals in the hoof no tobacco in the Director) will continuate the Area in the contacted the Area in the contact	ant A called the provider's taff #4 called him a name and in the group home van. The f Internal Investigation and into the group home van. The f Internal Investigation and into the cours after the allegation to was doing. He was in good the time he made the phone was doing. He was in good the time he made the phone was mad at the time and the fact of the cours after #4] because [staff in out for an extra outing. was mad at the time and was mad at the time and was he in the company van. [Client in the company van. [Client in the company van. [Client in the company van. [Staff #4] was no longer mad at [staff #4] wap [Staff #4] did state that then does vape (sic) it is in the vareas [Staff #2] was no and he stated he was in the wand [staff #4] was vaping and is a cartridge or vape with conclusion of the investigation in the information found tion, and [client A] reporting staff #4], there isn't any that the allegation as it was will receive corrective in the van and all staff and the one will review the guideline vans. The PD (Program		TAG	Persons Responsible: Progras Supervisor, Program Director (QIDP), Area Director		DATE

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	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì í		INSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING	00	COMPL	
		15G300	B. W	ING		03/09/	/2021
NAME OF D	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	_	
NAME OF I	KOVIDEK OK SOIT EIEF			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	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
	(staff #4) was verba	ally, physically and					
		e. The allegation included an					
	-	4 and client A getting into a					
	-	taff #4 calling client A a					
		" The allegation indicated					
	-	ne to go to his mom's house					
		m the group home to smoke					
		egation indicated staff #4					
	smoked marijuana i	in the group home using a					
	vape. The allegation	on indicated a former staff was					
	the only person on t	the clients' bank accounts					
	therefore the former	r staff had to meet the clients					
	at the bank in order	for them to get money.					
		Fact section indicated, "The					
	-	ot substantiate the allegations					
		nous report of verbal, physical					
		e by [staff #4] toward any ome. The investigation did					
		allegations made in the					
		of [staff #6] and [staff #4]					
		nigh' and working that way					
		hift. The Program Director					
	-	tellectual Disabilities					
		omplete unannounced					
		home during the week to					
	monitor interactions	•					
	individuals."	-					
	Following the inves	stigation, the PD conducted					
	observations at the	group home on 2/23/21,					
	2/24/21, 2/25/21 an	d 3/4/21. There have been					
	no observations cor	nducted of staff #4 and staff					
		ere not reporting to work					
		of marijuana. There were no					
		vations conducted of staff #4					
	-	ensure his interactions with					
	the clients were app	propriate.					
	On 3/8/21 at 2:14 P	M, the PD indicated she					
		,					

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA			INSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	B. W	UILDING	00	COMPL	
		15G300	B. W	ING		03/09/	2021
NAME OF F	ROVIDER OR SUPPLIER	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF I	NO VIDEN ON BOTTELES	•		110 W F	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 APPROPRI	ATF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	conducted observat	ions at the group home					
	however none of the	e observations included staff					
	-	indicated she would ensure					
		rvations at the group home					
	when staff #4 and #	6 were working.					
	On 3/9/21 at 11:07	AM the Quality					
		alist stated "that would make					
		ons would have been					
	conducted of them.						
	On 3/9/21 at 11:18	AM, the Area Director					
	indicated observation	ons of staff #4 and #6 should					
	have been conducte	ed.					
	0) 0 0/5/04 . 44						
	1	44 PM, the Area Director					
		a BDDS report attached. The					
	-	on 3/4/21, during a complaint					
		by ISDH (Indiana State lth), [client A] asked to speak					
	-	nd Area Director for Indiana					
		orted that on 2/27/21 and					
	-	come to his bedroom to get					
		med pass and dumped a					
		on his head to wake him up.					
		that this caused his bed to get					
	wet as well. He rep	oorted that no other staff					
	observed this incide	ent, but other staff were in the					
		The staff reported to be					
		was immediately suspended					
		ation into the allegation.					
		he was not injured. No other					
		have reported this type of					
		staff. An investigation is					
		the Quality Improvement					
		sory staff will continue to					
		s between individuals and					
		iff will continue to follow					
		tich has a target behavior of tions against staff. [Client A]					
	making raise anega	nons against starr. [Cliciit A]					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G300	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	COMI	E SURVEY PLETED 9/2021
	PROVIDER OR SUPPLIER		110 W	ADDRESS, CITY, STATE, ZIP COE PIKE ST NSVILLE, IN 46151	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ID  NCY MUST BE PRECEDED BY FULL PREFIX  R LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
TAG	reported he doesn't him working in the from the investigatin health and safety of On 3/4/21 at 12:35 and woke him up on pouring ice water on the surveyor a pictur bed). Client A indicacross the street to be marijuana during hi don't want to be her indicated staff #4 can did not recall the na informed staff #1 ar #4 pouring water or staff #4 took client of everyone in the group on 3/3/21, staff #4 to wings for everyone stated, "Don't want getting out of control #4 yelled at client D did not report it. needs to be out of he client A indicated he staff #1 on 2/28/21.  On 3/8/21 at 5:07 Pinvestigation was consummary section in	LISC IDENTIFYING INFORMATION)  like this staff and doesn't like home. Recommendations on will be followed for the fall individuals in the home."  PM, client A indicated staff 2/27/21 and 2/28/21 by in his head (client A showed re on his phone of his wet cated staff #4 continued to go his mom's house to smoke is shifts. Client A stated, "I with him." Client A alled him a name however he me. Client A indicated he had staff #5 on 3/1/21 of staff in his head. Client A indicated G's money to buy wings for up home. Client A indicated alked client C into buying at the group home. Client A to be here with him. He's bol." Client A indicated staff to on 2/28/21 however client Client A stated, "[Staff #4] ere." On 3/4/21 at 1:10 PM, he reported the allegation to  M, a review of the 3/8/21 briducted. The Incident dicated, "On 3/4/21, during a	TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)	ROPRIATE	DATE
	asked to speak with Director for Indiana on 2/27/21 and 2/28 come to his bedroor med pass and dump his head to wake his	the home by ISDH, [client A] the surveyor and Area MENTOR, and reported that 3/21, a staff (staff #4) had in to get him up for morning ed a bucket of ice water on in up. [Client A] reported that to get wet as well. He				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO. JILDING	NSTRUCTION	(X3) DATE		
ANDILAN	OF CORRECTION	15G300	B. W		00	03/09/	
		15G300	D. W.		<u>.</u>	03/09/	2021
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
				110 W F			
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 APPROPRI	ΔTF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	\\L	DATE
	reported that no oth	er staff observed this					
	incident, but other s	taff were in the home at the					
	time. The staff repo	orted to be involved was					
	immediately suspen	ded pending an investigation					
	-	[Client A] reported he was					
	•	er individuals or staff have					
		f behavior from this staff. An					
	-	ng conducted by the Quality					
		alist. Supervisory staff will					
		interactions between					
		f for safety. Staff will					
	-	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							
		_					
		lations from the investigation					
		the health and safety of all					
		ome." The Conclusions of					
		ed, "Evidence supports that aff #4] pouring water on the					
	-	s unsubstantiated." The					
		t include recommendations.					
	investigation did no	t metade recommendations.					
	On 3/4/21 at 12:51	PM, client D stated he "can't					
		44 yelled at him or not on					
	2/28/21.	,					
	On 3/4/21 at 1:00 P	M, the Area Director (AD)					
	indicated she susper	nded staff #4. The AD					
	indicated staff #4 re	ported he had irritable bowel					
	syndrome and had t	o go to his mom's house					
	across the street in o	order to use the restroom					
	-	n 3/4/21 at 1:17 PM, the AD					
		r Program Supervisor was					
		ank accounts. The AD					
	indicated she was w	orking on getting it resolved.					
	O., 2/4/21 + 1.04 B	M. Alex Dura survey Co.					
		M, the Program Supervisor					
		vas aware of the allegation of er dumped on his head on					
	Chem A naving wat	er dumped on ms nead on					

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	OF CORRECTION	IDENTIFICATION NUMBER:  15G300	A. BUILDING 00  B. WING		COMPLETED 03/09/2021	
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE		
TRANSIT	TIONAL SERVICES	SUB LLC		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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
	3/1/21. The PS indithe PD on 3/1/21 of stated she "assumed The PS indicated sta allegation to her on she was aware staff during his shifts for go across the street. aware staff #4 "sme start of his shifts. TA]. Says nothing is 2:11 PM, the PS indicated staff #2. The PS of client A by staff # the PS indicated she against staff #4. Th reported the allegati indicated staff #5 alsher on 3/1/21. The indicated she texted 3/1/21 at 8:07 PM. report the allegation On 3/4/21 at 1:39 PI G was missing \$50.0 \$50.00. She indicated Program Director. Sand staff #2 both she with client A. She i #1 and #2 taking client A]. voice at him telling	cated indicated she informed the allegation. The PS it was reported to [AD]." aff #1 did not report the 2/28/21. The PS indicated #4 left the group home 30-45 minutes at a time to The PS stated she was lled like marijuana" at the he PS stated, "Poor [client being done." On 3/4/21 at dicated client A sold his vape stated this was "exploitation" #2. On 3/4/21 at 2:57 PM, was aware of the allegations e PS indicated client A on to her on 3/1/21. The PS is or reported the allegation to PS, after checking her phone, the allegation to the PD on The PS indicated she did not to the AD.  M, staff #6 indicated client A had ed she reported it to the Staff #6 indicated staff #1 ared their chewing tobacco indicated this included staff ent A's chewing tobacco.  M, staff #8 indicated client On recently and client A had  M, staff #5 stated "[staff #4]  He bullies him. Raises his				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO JILDING	00	(X3) DATE COMPL		
		15G300	B. W		00	03/09/	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF			110 W F	PIKE ST		
TRANSIT	TIONAL SERVICES	SUB LLC		MARTIN	NSVILLE, IN 46151		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	PLAN OF CORRECTION	
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL  I SC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		LSC IDENTIFYING INFORMATION) missing \$50.00. The PD		TAG	DEFICIENCE		DATE
		reported to BDDS. The PD					
		nown about it for 2 days and					
	should have reporte	d it to BDDS within 24 hours.					
		lient A told her on 3/4/21 he					
	-	ff #2 for \$60.00. The PD					
	-	ion." The PD indicated she					
	-	oout staff #4 pouring water on ed it happened. The PD					
		taff #4 to stay away from					
		as a second staff with him when					
	^	lient A. The PD stated staff					
	#1 and staff #2 taki	ng/borrowing chewing					
tobacco from client A was "another example of							
	exploitation." On 3/8/21 at 2:15 PM, the PD						
		igation was completed on					
		icated there was no evidence					
		oured water on client A to PD indicated staff #4 returned					
	to work on 3/7/21.	PD indicated stail #4 returned					
	to work on 3/7/21.						
	On 3/5/21 at 10:39	AM, a review of client A's					
		ized Support Plan (ISP)					
		rget behaviors and definition					
		ior Support Plan: Aggression					
		ructive to property, socially					
		uncooperative behavior, vior, elopement, and					
	,	ng" Client A's 2/10/21					
		lan (BSP) indicated, "					
		erbal and can communicate					
	his wants and needs	s effectively" The BSP					
	_	geted behavior section,					
	-	ehavior is defined as, but not					
		other's possessions and					
		to give him money, and lying					
	and/or falsely accus	ing staff and peers."					
	On 3/8/21 at 12:24	PM, the facility's Quality and					
		policy, dated April 2011, was					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G300		A. BUILDING  B. WING	<u>00</u>	COMPLETED 03/09/2021			
	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)	(X5) COMPLETION DATE		
W 0153 Bldg. 00	Mentor promotes a laseeks to protect indices to protect indices and seeks to protect indices and through a proces and reducing risk to exposed" The Appolicy indicated, in are prohibited by en MENTOR: abuse, no mistreatment of an individual's rights."  This federal tag relation and individual's rights."  This federal tag relation and individual's rights."  This federal tag relation and individual's rights."  The facility must emistreatment, negginjuries of unknow immediately to the officials in accordates and G, the facility immediately reported the administrator and report to the Bureau individual services and report to the Bureau individual services and report to the Bureau individual services and services are services and services	cures and company contoring of service delivery ses of identifying evaluating which individuals are oril 2011 Human Rights part, "The following actions apployees of Indiana eglect, exploitation or andividual including misuse ands; or violation of an  ENT OF CLIENTS assure that all allegations of adect or abuse, as well as an source, are reported administrator or to other ance with State law through adures. iew and interview for 2 of 5 ans reviewed affecting clients of failed to ensure staff and an allegation of abuse to d submitted an incident of Developmental as (BDDS) within 24 hours, in	W 0153	Staff in the home were retrained on the prevention of abuse, neglect, exploitation and mistreatment, reporting incider timely and following/implement corrective actions as written or 3/15/21.  The Program Director (QIDP) retrained on 3/15/21 on submit incident reports to BDDS timel and following developed correctives.	nts ting n was tting		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15G300	B. WI	NG		03/09/	2021
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				PIKE ST		
TRANSIT	IONAL SERVICES	SUBLIC			NSVILLE, IN 46151		
	TOTAL OLIVIOLO			WIZIXIII	10 VILLE, IIV 40 10 1		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
		AM, a review of the facility's			actions as written following		
	_	ve reports was conducted and			investigations.		
	indicated the follow	ing:			The Program Director (QIDP)		
					Area Director will meet weekly		
		44 PM, the Area Director			three months and then monthly		
		BDDS report attached. The			ongoing to review that incident		
	_	n 3/4/21, during a complaint			reports are submitted timely ar	าต	
	-	by ISDH (Indiana State			that corrective actions are		
	_	th), [client A] asked to speak			implemented as written.		
	-	nd Area Director for Indiana			Persons Responsible: Program	П	
	_	orted that on 2/27/21 and come to his bedroom to get			Supervisor, Program Director		
	·	9			(QIDP), Area Director		
		med pass and dumped a on his head to wake him up.					
		that this caused his bed to get					
		orted that no other staff					
	_	nt, but other staff were in the					
		The staff reported to be					
		was immediately suspended					
		ation into the allegation.					
		he was not injured. No other					
		have reported this type of					
		staff. An investigation is					
		the Quality Improvement					
		sory staff will continue to					
	monitor interactions	between individuals and					
	staff for safety. Sta	ff will continue to follow					
	[client A's] BSP wh	ich has a target behavior of					
		tions against staff. [Client A]					
	reported he doesn't	like this staff and doesn't like					
	_	home. Recommendations					
		on will be followed for the					
	health and safety of	all individuals in the home."					
		PM, client A indicated staff					
	-	2/27/21 and 2/28/21 by					
	pouring ice water on his head (client A showed						
		re on his phone of his wet					
		cated he informed staff #1					
	and staff #5 on 3/1/2	21 of staff #4 pouring water					

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	OF CORRECTION	IDENTIFICATION NUMBER:  15G300	A. BUILDING 00  B. WING		COMPLETED 03/09/2021	
	PROVIDER OR SUPPLIER		110 W	ADDRESS, CITY, STATE, ZIP CODE PIKE ST INSVILLE, IN 46151		
(X4) ID PREFIX TAG	(EACH DEFICIENG REGULATORY OR on his head. On 3/4	CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) /21 at 1:10 PM, client A d the allegation to staff #1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
	(PS) indicated she we client A having water The PS indicated into on 3/1/21 of the alled "assumed it was repindicated staff #1 disher on 2/28/21. On indicated she was asstaff #4. The PS incompleted allegation to her on staff #5 also reported 3/1/21. The PS, after indicated she texted 3/1/21 at 8:07 PM. report the allegation on 3/8/21 at 3:37 PM. report the allegation and mistadministrator. The for reporting incident administrator. The for reporting incident 2) A 3/5/21 BDDS 12:45 PM, "during (Indiana State Depa was made that [client his cash on hand in was immediately state preliminary reviewed discrepancy of \$14.5 on his cash on hand available"	M, the Program Supervisor vas aware of the allegation of er dumped on his on 3/1/21. dicated she informed the PD gation. The PS stated she orted to [AD]." The PS d not report the allegation to 3/4/21 at 2:57 PM, the PS ware of the allegations against dicated client A reported the 3/1/21. The PS indicated d the allegation to her on er checking her phone, the allegation to the PD on The PS indicated she did not to the Area Director.  M, the Quality Improvement dicated the staff should allegations of abuse, neglect, streatment to the QIS indicated the timeframe and the total properties of the properties of a possible properties of the pr				

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		15G300	B. WING		03/09/2021	
	D 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		STREET A	ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF P	ROVIDER OR SUPPLIER			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 APPROPRIA	TE COMPLETION	1
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
		cted. Client G's January 2021				
	Cash on Hand Record indicated he had a balance of \$4.54. When the PS counted client G's					
	•	64. Client G's balance was				
	over by \$9.10.					
	On 3/4/21 at 1:39 PM, staff #6 indicated client					
		00 recently and client A had				
	_	ed she reported it to the				
	Program Director.					
	5					
	On 3/4/21 at 1:39 PM, staff #8 indicated client					
	G was missing \$50.00 recently and client A had					
	\$50.00.					
		M, the Program Director				
		neard client G was missing				
		licated it was not reported to				
		licated she had known about it				
	within 24 hours.	ld have reported it to BDDS				
	Within 24 nours.					
	On 3/8/21 at 3·55 P	M, the Quality Improvement				
		icated incidents should be				
	reported to BDDS v					
	•					
	9-3-2(a)					
W 0457	400 400( 1)(4)					
W 0157	483.420(d)(4)	INT OF CLIENTS				
Dida oo	STAFF TREATME					
Bldg. 00	orrective action n	tion is verified, appropriate				
		riew and interview for 1 of 3	W 0157	Staff in the home were retrain	ad 04/09/202	1
		e (A), the facility failed to	W 0157	on the prevention of abuse,	ed 04/08/202	1
	-	corrective action was taken		neglect, exploitation and		
	* * *	tion of abuse at the home.		mistreatment, reporting incide	nts	
		ensure administrative		timely and following/implemen		
	_	up home included the staff		corrective actions as written o	_	
	involved in the alleg			3/15/21.		
		-		The Program Director (QIDP)	was	

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	OF CORRECTION	IDENTIFICATION NUMBER:  15G300	A. BUILDING 00  B. WING		COMPLETED 03/09/2021	
	PROVIDER OR SUPPLIER		110 W	ADDRESS, CITY, STATE, ZIP CODE PIKE ST		
TRANSH	IONAL SERVICES	SUB LLC	MARTI	NSVILLE, IN 46151		
	SUMMARY ST (EACH DEFICIENCE REGULATORY OR Findings include:  On 3/4/21 at 10:55 A incident/investigative indicated the follow.  On 2/23/21, Adult P the Area Director to incident report alleg #6) at the group hone working and one of verbally, physically allegation included a client A getting into calling client A a "stallegation indicated to his mom's house a group home to smok indicated staff #4 sn home using a vape. former staff was the bank accounts there meet the clients at the get money.  The Conclusions of investigation did not incident included in the conclusions of investigation did not incident.	SUB LLC  CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  AM, a review of the facility's re reports was conducted and ring:  Protective Services contacted report she received an ring two staff (staff #4 and re smoke marijuana while the staff (staff #4) was and emotionally abusive. The ran allegation of staff #4 and ra physical fight and staff #4 rupid f idiot." The staff #4 left the home to go recross the street from the re marijuana. The allegation rocked marijuana in the group The allegation indicated a only person on the clients' fore the former staff had to re bank in order for them to  Fact section indicated, "The t substantiate the allegations	STREET A		(X5) COMPLETION DATE  tting y ctive  and for y t nd	
	made in the anonym and emotional abuse individuals in the ho not substantiate the	ous report of verbal, physical by [staff #4] toward any ome. The investigation did allegations made in the f [staff #6] and [staff #4]				
	reporting to work 'hi during their work sh (QIDP/Qualified Int Professional) will co	igh' and working that way ift. The Program Director ellectual Disabilities omplete unannounced nome during the week 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 03/09/2021		
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 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		
	observations conducto ensure they were the influence of mar unannounced observaturing his shifts.	tigation, there have been no cted of staff #4 and staff #6 not reporting to work under rijuana. There were no vations conducted of staff #4					
	conducted observation however none of the #4 and #6. The PD	M, the PD indicated she ions at the group home e observations included staff indicated she would ensure rvations at the group home 6 were working.					
		alist stated "that would make ons would have been					
		AM, the Area Director ons of staff #4 and #6 should d.					
	This federal tag rela#IN00347983.	ites to complaint					
	9-3-2(a)						
W 0227 Bldg. 00	specific objectives client's needs, as	gram plan states the necessary to meet the identified by the ssessment required by					
	Based on observation review for 1 of 4 not facility failed to ens	on, interview and record on-sampled clients (F), the oure client F had a plan for group home to prevent him	W 0227	Client F's team is in the proce of scheduling a meeting and t meeting will address making updates to his program plan for securing pens following their up	his or		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G300		(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPLETED  03/09/2021		
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	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		
	Findings include:		in the home to prevent him fro writing on his bedroom walls o other walls in the home. The w	r		
	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.		in Client F's bedroom was pair before the survey exit was completed and if there are issured with this in the future, the wall again be repainted timely. A weekly checklist will be completed by supervisory staff observe items listed on this placorrection are completed to ensure the home remains in grepair.  Persons Responsible: Progra Supervisor, Program Director (QIDP), Area Director	ues will f to an of pod		
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 temperature in the home on a regular basis individuals' safety on 3/15/21.	ires		

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:  15G300	A. BUILDING 00  B. WING		COMPLETED 03/09/2021		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
TRANSITIONAL SERVICES SUB LLC			MARTINSVILLE, IN 46151				
	SUMMARY ST. (EACH DEFICIENCE REGULATORY OR degrees Fahrenheit.  Findings include:  On 3/4/21 from 12:0 observation was cord During the observation was the surveyor washed and the water temperature. The find the provider was broken facility was unable to the thermometer. The find the facility was unable to the the facility was unable to the facility was unab	SUB LLC  TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  OF PM to 3:30 PM, an adducted at the group home, ion at the group home, the in the kitchen sink, bathroom is 125 degrees Fahrenheit.  Id his hands in the kitchen sink arature was greater than 110  The surveyor asked the staff meter to test the water termometer the facility in and did not work. The provide a working facility did not have a working the water temperature at the effected clients A, B, C, D, E,  M, a review of the facility's documentation from March 2021 was conducted, test the water temperature in a 2021 prior to the surveyor		110 W PIKE ST		tely All one e. e ue ures to an of	(X5) COMPLETION DATE
	Water Temperature temperature exceeds needs to be adjusted adjusted, staff must individuals who can water temperature. immediately if temp Fahrenheit. The suptemperature is adjusted On 3/4/21 at 3:14 Pl	M, the Area Director temperature should not					

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AND PLAN	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		X2) MULTIPLE CONSTRUCTION  A. BUILDING 00  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  110 W PIKE ST  MARTINSVILLE, IN 46151  ID  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
W 0455 Bldg. 00	9-3-7(a)  483.470(I)(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.	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 availation use at all times on 3/15/21. A weekly checklist will be completed by supervisory staff observe items listed on this placorrection are completed to ensure soap is in the bathroom and kitchen at all times for use the health and safety of all individuals' and staff. Persons Responsible: Prograf Supervisor, Program Director (QIDP), Area Director	ng e ble to an of for

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