STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	DING	00	COMPLETED	
		15G300	B. WING	B. WING 08/11/			2022
				CTREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIE	R			PIKE ST		
TRANSIT	IONAL SERVICES	SSUBJEC	MARTINSVILLE, IN 46151				
11011011	TOWNE BETTWIBE		,	1017 (1 (1 1 1	NOVIELE, IIV 40101		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΤE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
W 0000							
DI4= 00							
Bldg. 00	TT1: ::/ C /1		117.00	00			
		he investigation of complaint	W 00	00			
	#IN00384168.						
	Complaint #INO039	84168 - Substantiated. Federal					
	_	es related to the allegation(s)					
		2, W104, W122, W127, W149,					
		66, W157, W159, and W252.					
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	70, W157, W155, and W252.					
	Unrelated deficience	cies cited.					
	Survey dates: Augu	ust 8, 9, 10 and 11, 2022					
	Facility Number: 0	00819					
	Provider Number:	15G300					
	AIM Number: 1002	249100					
		also reflect state findings in					
	accordance with 46						
	· •	this report completed by #15068					
	on 8/19/22.						
W 0102	402 440						
VV U 102	483.410	DY AND MANAGEMENT					
Bldg. 00		ensure that specific					
Blug. 00	governing body a	·					
	requirements are	•					
	•	on, interview and record	W 010	02	The QIDP (PD) is no longer wi	ith	09/10/2022
		ients living in the group home	WUI	02	Indiana Mentor as of 8.5.22.		09/10/2022
		G and H), the facility failed to			record will reflect that she will		
		of Participation: Governing			be re-hirable at Indiana Mento		
		's governing body failed to			to a substantiation of neglect	1 duc	
		direction over the facility by			stemming from an investigation	n in	
		versight and monitoring of the			a different home. She left before		
		al Disabilities Professional			corrective action could be take		
		ne QIDP performed her duties			on the results of the survey	***	
		ng recognizing an allegation of			findings for this survey.		
	_	tential abuse was mitigated			(Specifically recognizing, repo	rtina	
					(Cp30indany 1000ginzing, 10p0i	9	

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

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo 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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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G300	B. W	ING		08/11/	/2022
		l		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	8			PIKE ST		
TRANGIT	IONAL SERVICES	SUBLIC			NSVILLE, IN 46151		
HOANSH	TONAL SERVICES			IVIZARATI	NOVILLE, IIN 40131		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	ļ	TAG	DEFICIENCY)		DATE
	-	tion by immediately			and following policy for Abuse		
	suspending staff, ensuring staff documented an				Neglect and Exploitation and a		
	incident of client A getting punched in the face by				reporting and investigating clie		
	staff was documented, ensuring the van seating				client aggression) A New Hir		
	-	nanged following an incident in			checklist has been implement		
	the van, and providing and/or ensuring				that addresses the rehire eligil	bility	
	administrative oversight of the group home was				status.	_	
	increased following an incident of substantiated				The current PD will be retrained		
	staff abuse of client A. The governing body				and the new PD (QIDP) will be		
	failed to ensure client A was not subjected to				trained on the Supervisor Site		
	physical, verbal or psychological abuse or				review expectations. The		
		overning body neglected to			Supervisor Site Review form is		
		ies and procedures to prevent			be turned into the Area Directo		
		nd G, conduct a thorough			(Regional Director in the abse	nce	
	-	ff abuse of client A and an			of an AD) monthly to ensure		
		client aggression at the	oversight of the PD.A PD has				
		y program, prevent further	been assigned to the home to				
		estigation was in process,			provide oversight and monitor	-	
		f the investigation were			individuals, their plans and the		
	-	inistrator within 5 working			home until a new PD (QIDP) is		
		opriate corrective actions			trained (Hired to start 9.12.22)		
		s of an investigation. The			The acting PD will be retrained		
		ed to ensure the dishwasher			recognizing and reporting ANE		
		g order and a hole in the			and following ANE policy. The		
	upstairs hallway wa	s repaired in a timely manner.			new PD (QIDP) will be trained	on	
					recognizing and reporting		
	Findings include:				allegations of Abuse, Neglect		
	1) 11	W104 E 0 CO 1' - 1' '			Exploitation and IM policies.	The	
	· ·	V104. For 8 of 8 clients living in			training will include how to		
		B, C, D, E, F, G and H), the			investigate and a review of the		
		body failed to exercise			guidelines for timeliness noted	in	
		over the facility by failing			the Indiana Mentor policy.		
		not subjected to physical,			The van seating arrangement		
		rical abuse or punishment.			changed with a voluntary seat	ıng	
		y failed provide oversight and			chart that was implemented		
	monitoring of the Qualified Intellectual Disabilities				8.11.22. Client A does not alv	-	
) to ensure the QIDP performed			adhere to the seating chart bu		
	_	ed including recognizing an			there has not been any further		
	-	ensuring potential abuse was			instances of disruptive behavio		
	mitigated during an investigation by immediately				while in the vehicle. The tear	n will	

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G300	B. W	ING		08/11/	2022
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	L.			PIKE ST		
TDANGIT	TIONIAL SERVICES	SUBLIC			NSVILLE, IN 46151		
IRANSII	TIONAL SERVICES	30B LLC		WARTII	13VILLE, IN 40131		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	suspending staff, en	suring staff documented an			continue to monitor Client A's		
	incident of client A getting punched in the face by				behavior on the van and if it is		
	staff was documented, ensuring the van seating				determined that he needs to b	е	
	arrangement was changed following an incident in		restricted from sitting behind the				
	-	a thorough investigation of			driver or in the front seat it will	be	
		A and an incident of client to			added to his Behavior Support	t	
		roviding and/or ensuring			Plan and ISP subject to HRC		
		sight of the group home was			approval. The PD will monitor	by	
	_	an incident of substantiated			reviewing documentation and		
		A. The governing body			incident reports during the wee	ekly	
		dishwasher remained in			Supervisory Visits		
	_	a hole in the upstairs hallway			The QIS was retrained by the		
	was repaired in a timely manner.				Quality Improvement Manager	on	
					7.26.22. This was after the		
	1	V122. For 1 of 3 clients in the			investigation noted in this surv	-	
		additional client (G), the			was done but before this surve	Э У	
		ed to meet the Condition of			was completed. The		
	-	t Protections. The governing			investigations done by the QIS		
	-	re client A was not subjected			were reviewed for a period of		
		or psychological abuse or			days by either the QI Managei		
		overning body neglected to			another member of the QI teal		
		ies and procedures to prevent			ensure the investigations done		
		nd G, conduct a thorough			were thorough and completed		
	_	f abuse of client A and an			within the 5 day time frame.		
		client aggression at the			Regional Director will monitor	the	
		y program, prevent further	1		QIS while completing		
		estigation was in process,			investigations to ensure the 5		
		f the investigation were			time frame is adhered to and v		
	-	inistrator within 5 working			review the investigation to ens	ure	
		opriate corrective actions			it is thorough.		
	regarding the results	s of an investigation.			A communication book will be		
	Th:- f-1141-	441-:4 #INIO0294169			created for use by the group h		
	i mis rederai tag rela	ites to complaint #IN00384168.			and day program staff to ensu		
	0.3.1(a)				staff are aware of any informa		
	9-3-1(a)				needed that might affect the care		
					of the individuals. The Progra	4111	
					Director will review the book	ion	
					weekly to ensure communicati	ION	
					Occurs. The Drogram Supervisor in the	_	
			1		The Program Supervisor in the	=	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/19/2022 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES		OM	B NO. 0938-039	
	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/11/2022	
	PROVIDER OR SUPPLIEF		110 W	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	лтЕ	(X5) COMPLETION DATE
				home is reaching out to contractors for quotes to repair wall and also repair or replaced dishwasher. The Program Director will touch base at least weekly to monitor the status or repairs. The Program Director will retrathe Program Supervisor and a other staff in the home documentation requirements of daily notes and also behavior tracking and unusual incidents. This will be monitored as described in the Supervisor Sivisit checklist form. The Nursing staff will reach out Client B's psychiatrist to determine what the appropriate course of treatment would be the possible reoccurrence of trichotillomania symptoms. Depending on the recommendations the Individual Support Plan and Behavior Support Plan will be updated a staff trained on any changes. The Nursing staff will reach out Client C's psychiatrist for an appointment to be evaluated for diagnosis of Pica. If Client C is given the diagnosis of Pica his Individual Support Plan will be updated and staff trained on changes. Responsible Parties: Region	e the st of the st of the ain all for s. ite ut to te for and ut to ior a is	

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Director, Program Director, Program Supervisor and Nurse

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G300		A. BU	A. BUILDING <u>00</u> CO			DATE SURVEY OMPLETED 8/11/2022	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 110 W PIKE ST MARTINSVILLE, IN 46151			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ίΤΕ	(X5) COMPLETION DATE
W 0104 Bldg. 00	policy, budget, and	DY dy must exercise general d operating direction over					
	review for 8 of 8 cli (A, B, C, D, E, F, G body failed to exerc the facility by failin subjected to physica abuse or punishmen provide oversight at Intellectual Disabili ensure the QIDP pe including recognizit ensuring potential a investigation by immensuring staff documented, ensurin arrangement was che the van, conducting staff abuse of client client aggression, pr administrative overs increased following staff abuse of client failed to ensure the working order and a was repaired in a tin Findings include: 1) Please refer to W incident/investigativ client A, the govern	aanged following an incident in a thorough investigation of A and an incident of client to roviding and/or ensuring sight of the group home was an incident of substantiated A. The governing body dishwasher remained in a hole in the upstairs hallway mely manner. V127. For 1 of 5 we reports reviewed affecting ing body failed to ensure ojected to physical, verbal or	W 0	104	The QIDP (PD) is no longer will indiana Mentor as of 8.5.22. It record will reflect that she will be re-hirable at Indiana Mentor to a substantiation of neglect stemming from an investigation a different home. She left before corrective action could be taken on the results of the survey findings for this survey. (Specifically recognizing, reporting and investigating client aggression) A New Hirt checklist has been implemented that addresses the rehire eligilistatus. A PD has been assigned to the home to provide oversight and monitoring of individuals, their plans and the home until a new PD (QIDP) is trained (Hired to start 9.12.22). The acting PD will be retrained on recognizing and reporting ANE and following A policy. The new PD (QIDP) witrained on recognizing and reporting allegations of Abuse Neglect and Exploitation and I policies. The training will inchow to investigate and a reviet the guidelines for timeliness on in the Indiana Mentor policy. The current PD will be retrained.	Her not or due on in ore en orting salso ent to se ed bility se diction will be self ill b	09/10/2022

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G300		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 08/11/2022	
	ROVIDER OR SUPPLIER		110 W	ADDRESS, CITY, STATE, ZIP COD PIKE ST INSVILLE, IN 46151	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
PREFIX TAG	2) Please refer to V incident/investigative clients A, C and G, to implement its poprevent abuse of the investigation of statincident of client to facility-operated da abuse while the invensure the results of reported to the adm days, and take appregarding the result. 3) Please refer to V incident/investigative clients A, C and G, conduct a thorough of client A and an inaggression at the factorial three potentials and G, the prevent further potentials and G. Please refer to V incident/investigative clients A and G, the prevent further potentials abuse.	A LSC IDENTIFYING INFORMATION W149. For 2 of 5 we reports reviewed affecting the governing body neglected licies and procedures to e clients, conduct a thorough if abuse of client A and an client aggression at the y program, prevent further estigation was in process, if the investigation were inistrator within 5 working opriate corrective actions s of an investigation. W154. For 2 of 5 we reports reviewed affecting the governing body failed to investigation of staff abuse incident of client to client cility-operated day program. W155. For 1 of 5 we reports reviewed affecting the governing body failed to investigation of staff abuse incident of client to client cility-operated day program. W155. For 1 of 5 we reports reviewed affecting the governing body failed to intial abuse of the clients income by failing to suspend y following an allegation of	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	e sto or ence was ting ways at ror or will so be the I be t r by ekly
	reported to the adm days.	f an investigation were inistrator within 5 working		was done but before this surv was completed. The investigations done by the QI were reviewed for a period of	S 30
	clients A and G, the	V157. For 1 of 5 we reports reviewed affecting governing body failed to corrective actions were		days by either the QI Manage another member of the QI tea ensure the investigations don were thorough and completed	m to e

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 15G300 B. WING 08/11/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 110 W PIKE ST TRANSITIONAL SERVICES SUB LLC MARTINSVILLE, IN 46151 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE implemented to address a substantiated allegation within the 5 day time frame. The of abuse involving client A. Regional Director will monitor the QIS while completing 7) On 8/8/22 from 3:20 PM to 4:51 PM, an investigations to ensure the 5 day observation was conducted at the group home. time frame is adhered to and will During the observation, the dishwasher was not review the investigation to ensure working. There was a pile of dishes sitting on the it is thorough. side of the sink. This affected clients A, B, C, D, A communication book will be E, F, G and H. created for use by the group home and day program staff to ensure On 8/8/22 at 4:04 PM, the Program Supervisor (PS) staff are aware of any information indicated the dishwasher was not working. The needed that might affect the care PS indicated the dishwasher would start and then of the individuals. The Program mid-cycle, turn off and not complete the cycle. Director will review the book The PS indicated this was an on-going issue for weekly to ensure communication several weeks. occurs. The Program Supervisor in the On 8/8/22 at 4:24 PM, staff #7 indicated the home is reaching out to dishwasher had been broken for several weeks contractors for quotes to repair the requiring the clients and staff to have to hand wall and also repair or replace the wash all of the dishes. dishwasher. The Program Director will touch base at least On 8/10/22 at 11:00 AM, the Regional Director weekly to monitor the status of the (RD) was asked to provide documentation of a repairs. work order for the dishwasher. The RD indicated The Program Director will retrain since she was not aware the dishwasher was not the Program Supervisor and all working, she did not believe there was a work other staff in the home order. A work order was not received during the documentation requirements for survey. The RD indicated the dishwasher should daily notes and also behavior be in working order. tracking and unusual incidents. This will be monitored as 8) On 8/8/22 from 3:20 PM to 4:51 PM, an described in the Supervisor Site observation was conducted at the group home. visit checklist form. During the observation, there was a 6 inches by 6 The Nursing staff will reach out to inches hole in the upstairs hallway adjacent to Client B's psychiatrist to client F's bedroom. This affected clients A, B, C, determine what the appropriate

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D, E, F, G and H.

On 8/8/22 at 4:04 PM, the PS indicated the hole in

the wall had been present for weeks and needed

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Depending on the

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course of treatment would be for the possible reoccurrence of

trichotillomania symptoms.

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C	construction 00	(X3) DATE SURVEY COMPLETED
		15G300	B. WING	ADDRESS, CITY, STATE, ZIP COD	08/11/2022
	PROVIDER OR SUPPLIER FIONAL SERVICES		110 W	PIKE ST INSVILLE, IN 46151	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	(X5) COMPLETION DATE
IAG	to be repaired. On 8/8/22 at 4:24 P the wall had been the needed to be repaired. On 8/10/22 at 11:00 not aware of the hohome. The RD indirepaired.	M, staff #7 indicated the hole in nere for a few months and		recommendations the Individe Support Plan and Behavior Support Plan will be updated staff trained on any changes. The Nursing staff will reach or Client C's psychiatrist for an appointment to be evaluated diagnosis of Pica. If Client C given the diagnosis of Pica his Individual Support Plan and Behavior Support Plan will be updated and staff trained on changes. Responsible Parties: Region Director, Program Director, Program Director, Program Director,	and ut to for a is s
W 0120 Bldg. 00	SOURCES The facility must a meet the needs or Based on interview in the sample (A, B (G and H), the facil communication systems group home and the program. Findings include: On 8/8/22 at 11:50 Supervisor (PS) indicommunication systems staff and the day progroup home staff demorning at the facil without going into the same of th	AM, the day program Program licated there was no tem between the group home ogram. The PS indicated the ropped the clients of in the lity operated day program the building to communicate chaviors, and/or appointments	W 0120	A communication book will be created for use by the group and day program staff to ensistaff are aware of any informaneeded that might affect the of the individuals. The Program Director will review the book weekly to ensure communica occurs. Responsible Parties: Region Director, Program Director	nome ure ation care ram

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	15G300	A. BUILDING B. WING	<u>uu</u>	08/11/2022
	PROVIDER OR SUPPLIER		110 W	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	``	LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	for the day. The PS staff needed to esco the building and corprogram staff about home went. The PS staff were not comm being dropped off in program staff have them if/when anothe appointment. On 8/8/22 at 12:05 a communication be and the day program notebook or electron (RD) indicated them system between the program. The RD i should go into the box	indicated the group home rt clients A, B, C, G and H into municate with the day how the morning at the group sindicated the group home nunicating which clients were in the mornings so the day to rely on the clients to tell er client stays home or had an PM, a review was attempted of pook between the group home in. There was no binder, folder, mic system in place to review. AM, the Regional Director e should be a communication group home and the day indicated the group home staff			
W 0122	483.420(a) CLIENT PROTEC	TIONS			
Bldg. 00	The facility must ensure the rights of all clients. Therefore the facility must Based on record review and interview for 1 of 3 clients in the sample (A) and one additional client (G), the facility failed to meet the Condition of Participation: Client Protections. The facility failed to ensure clients A and G were not subjected to physical, verbal or psychological abuse or punishment. The facility neglected to implement its policies and procedures to prevent abuse of clients A and G, conduct a thorough investigation of staff abuse of client A and an incident of client to client aggression at the		W 0122	The QIDP (PD) is no longer we londing Mentor as of 8.5.22. I record will reflect that she will be re-hirable at Indiana Mentot of a substantiation of neglect stemming from an investigation a different home. She left beforective action could be taken on the results of the survey findings for this survey. (Specifically recognizing, reposition of 8.5.22.)	Her not or due on in ore en

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		15G300	B. W	ING		08/11/	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			PIKE ST		
TRANSI	TIONAL SERVICES	SUB LLC			MARTINSVILLE, IN 46151		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		y program, prevent further			and following policy for Abuse		
	abuse while the investigation was in process,				Neglect and Exploitation and		
	ensure the results of the investigation were reported to the administrator within 5 working				reporting and investigating clie		
	_	_			client aggression) A New Hir		
		opriate corrective actions			checklist has been implement		
	regarding the results of an investigation.				that addresses the rehire eligi	DIIITY	
	Pludings includes				status.	_	
	Findings include:				A PD has been assigned to the		
	1) Places refer to W127 For 1 of 5				home to provide oversight and		
	1) Please refer to W127. For 1 of 5 incident/investigative reports reviewed affecting				monitoring of individuals, their		
	_	e facility failed to ensure the			plans and the home until a ne		
		e facility failed to ensure the			PD (QIDP) is trained (Hired to		
	psychological abuse				start 9.12.22). The acting PD be retrained on recognizing a		
	psychological abuse	e or pumsiment.			,		
	2) Please refer to V	V140 For 2 of 5			reporting ANE and following A		
	1 '	ve reports reviewed affecting			policy. The new PD (QIDP) w	ill be	
	_	the facility neglected to		trained on recognizing and reporting allegations of Abuse,			
		ies and procedures to prevent			Neglect and Exploitation and		
		, conduct a thorough			policies. The training will inc		
		ff abuse of client A and an			how to investigate and a revie		
		client aggression at the			the guidelines for timeliness n		
		y program, prevent further			in the Indiana Mentor policy.	olou	
		estigation was in process,			The current PD will be retrained	ed e	
		f the investigation were			and the new PD (QIDP) will be		
		inistrator within 5 working			trained on the Supervisor Site		
	•	opriate corrective actions			review expectations. The		
	* *	s of an investigation.			Supervisor Site Review form i	s to	
					be turned into the Area Direct		
	3) Please refer to V	V154. For 2 of 5			(Regional Director in the abse		
	· ·	ve reports reviewed affecting			of an AD) monthly to ensure		
	_	the facility failed to conduct a			oversight of the PD.		
		ion of staff abuse of client A			The QIS was retrained by the)	
	-	lient to client aggression at			Quality Improvement Manage		
	the facility-operated				7.26.22. This was after the		
					investigation noted in this surv	/ey	
	4) Please refer to V	V155. For 1 of 5			was done but before this surv	-	
	incident/investigati	ve reports reviewed affecting			was completed. The	-	
	clients A and G, the	e facility failed to prevent			investigations done by the QIS	3	
	further notential abuse of the clients living at the				were reviewed for a period of		1

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	ING	00	COMPL	ETED
		15G300	B. WING			08/11/	/2022
			СТ	DEET A	DDDECC CITY CTATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP COD		
TDANCIT	IONAL SERVICES	CLIPILLO			PIKE ST		
TRANSII	IONAL SERVICES	SUB LLC	IVI	AKIII	NSVILLE, IN 46151		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	II)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PRE	FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TF.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TA	AG	DEFICIENCY)		DATE
	group home by faili	ng to suspend staff #1			days by either the QI Manager	r or	
	immediately follow	ing an allegation of physical			another member of the QI tear		
	abuse.				ensure the investigations done))	
			were thorough and completed				
	5) Please refer to W156. For 1 of 5 incident/investigative reports reviewed affecting				within the 5 day time frame.		
					Regional Director will monitor		
	clients A and G, the facility failed to ensure the				QIS while completing		
	results of an investig	gation were reported to the			investigations to ensure the 5	day	
	administrator withir	1 5 working days.			time frame is adhered to and v	-	
					review the investigation to ens		
	6) Please refer to W	V157. For 1 of 5			it is thorough.		
	incident/investigative reports reviewed affecting				Responsible Party: Regional		
	clients A and G, the facility failed to ensure				Director		
	appropriate corrective actions were implemented						
	to address a substan	tiated allegation of abuse					
	involving client A.						
	This federal tag rela	ates to complaint #IN00384168.					
	9-3-2(a)						
W 0127	483.420(a)(5)						
	PROTECTION OF	CLIENTS RIGHTS					
Bldg. 00	The facility must e	ensure the rights of all					
	clients. Therefore	, the facility must ensure					
	that clients are not	t subjected to physical,					
	verbal, sexual or p	osychological abuse or					
	punishment.						
	Based on record rev	view and interview for 1 of 5	W 0127	7	The QIDP (PD) is no longer wi	ith	09/10/2022
	incident/investigativ	ve reports reviewed affecting			Indiana Mentor as of 8.5.22. H	Her	
	client A, the facility	failed to ensure client A was			record will reflect that she will	not	
		ysical, verbal or psychological			be re-hirable at Indiana Mento	r due	
	abuse or punishmen	nt.			to a substantiation of neglect	ļ	
					stemming from an investigatio	n in	
	Findings include:				a different home. She left before	ore	
					corrective action could be take	n	
		PM, a review of the facility's			on the results of the survey	ļ	
	_	ve reports was conducted and			findings for this survey.	ļ	
	indicated the follow	ving:			(Specifically recognizing, repo	rting	
					and following policy for Abuse	,	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G300	B. W	ING		08/11/	2022
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD		
TDANCE	TIONAL SERVICES	CLIPILLO			PIKE ST		
IKANSI	TIONAL SERVICES	SOB LLC		WARTII	NSVILLE, IN 46151		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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 OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		PM, client A got upset with			Neglect and Exploitation and a	also	
	staff #1. The 5/14/22 Bureau of Developmental				reporting and investigating clie	ent to	
	Disabilities Services (BDDS) incident report				client aggression) A New Hir		
	indicated, "On 5/13/22, [client A] got upset with				checklist has been implement		
	_	e go on an outing. When he			that addresses the rehire eligi	bility	
	was reminded it wasn't his afternoon to go on an				status.		
	outing due to his outing being scheduled on				A PD has been assigned to th		
	Wednesdays, he became verbally and physically				home to provide oversight and		
	aggressive toward staff. He threw and hit staff				monitoring of individuals, their		
	with the house phone and kicked a hole in the				plans and the home until a ne		
	dining room. He then went after staff again				PD (QIDP) is trained (Hired to		
	physically and staff reported he put his arms up to				start 9.12.22). The acting PD		
		m hitting him and staff			be retrained on recognizing ar		
	_	eidentally hit [client A] in the			reporting allegations of ANE.		
	_	is arms and [client A] got hit in			new PD (QIDP) will be trained	on	
		nd they bled. [Client A] also			recognizing and reporting		
		e phone at [client G] and hit			allegations of Abuse, Neglect		
	_	Client A] was checked for			Exploitation. The training wil		
		d up and an ice pack was put			include how to investigate and	la	
		G] was checked for injuries as			review of the guidelines for		
		e and he said he was just sore.			timeliness noted in the Indiana	a	
		that staff hit him so staff was			Mentor policy.		
		an investigation and to			The current PD will be retrained		
		tive action or retraining needs			and the new PD (QIDP) will be		
	_	Staff will continue to follow			trained on the Supervisor Site		
		ehavior Support Plan). An			review expectations. The		
	_	e completed to determine if any			Supervisor Site Review form is		
		eed to be completed and if			be turned into the Area Directo		
		eds to be changed for his and			(Regional Director in the abse	nce	
	others' safety."				of an AD) monthly to ensure		
	C4-CC #1	-1-1 5/14/22 -B 1:			oversight of the PD.		
	•	nded on 5/14/22 after working			The QIS was retrained by the		
		:26 PM and 5/14/22 from 6:54			Quality Improvement Manage	r on	
		The facility failed to prevent			7.26.22. This was after the		
	further potential abuse while an investigation was				investigation noted in this surv	-	
	in progress.				was done but before this surve	еу	
	Th - (/27/22 I 11	-4 F-11 Ha Dana (* 1°)			was completed. The	,	
		nt Follow-Up Report indicated,			investigations done by the QIS		
		estigation was completed and			were reviewed for a period of		
	signed off by the Regional Director on 6/17/2022.				days by either the QI Manage	r or	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		15G300	B. W	'ING		08/11/	2022
				CTDEET /	ADDRESS CITY STATE ZID COD		
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD PIKE ST		
TDANGIT	TIONIAL SERVICES	SUBLIC			NSVILLE, IN 46151		
TRANSH	TIONAL SERVICES	SUB LLC		WARTII	15VILLE, IIV 46151		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	From the investigation	ion it was determined the			another member of the QI teal	m to	
	event was substantia	ated. Staff was terminated			ensure the investigations done	Э	
		Staff has not worked in the			were thorough and completed		
	home during the investigation"				within the 5 day time frame.	The	
					Regional Director will monitor	the	
	The 6/13/22 Internal Investigation indicated in				QIS while completing		
		client A asked him to go on an			investigations to ensure the 5		
		vening shift. Staff #1 told			time frame is adhered to and v		
		his outing on 5/11/22 and			review the investigation to ens	sure	
		at A started hitting the back of			it is thorough.		
		he van as well as hitting staff			Responsible Party: Regional		
		vas driving. Staff #1's statement			Director		
	_	indicated, "States he					
	_	ing he was told that in a					
	_	al situation you vound (sic)					
		protect yourself States that					
		PD] said that if he couldn't find					
		switch places with [staff #7]					
		ack out on their van ride to get					
		States he asked [PD] about the					
		him coming in the next day and					
	_	him if he wanted to come in.					
		the next morning and was					
		a.m States [former Area					
	_	l him and asked how it was					
		told him (sic) was being					
		because [client A's] parents					
		[client A] said he was					
	uncomfortable with	[staff #1]"					
	TI (/12/22 I						
		Il Investigation indicated in the					
	· ·	States [staff #1] called her first					
		States he reported he had hit					
		ne was rambling. States [staff					
	#1] reported he had						
		atives) and that [client A] was					
	_	he had to hit him to get out of					
		e understood that he had hit					
	_	PIA. That it wasn't					
	intentional States	[former Area Director]					

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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 08/11/2022			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 110 W PIKE ST MARTINSVILLE, IN 46151				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LLSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION		
TAG	suspended [staff #1 with [client A's] par [client A] to urgent States she does not nurse regarding his The 6/13/22 Internations staff #7's statement anyone to come in fleave." The 6/13/22 Internation client C's statement #1] and [staff #1] his The 6/13/22 Internation Client G's statement [staff #1]. States [staff #1]. A] created a hazard	LESC IDENTIFYING INFORMATION on Saturday after speaking rents. States no one took care regarding his nose. know if he was seen by the nose" Il Investigation indicated in "States they couldn't find for [staff #1] so he could Il Investigation indicated in , "States [client A] hit [staff it [client A] and he cried" Il Investigation indicated in , "States [client A] charged taff #1] hit him in the mouth" Il Investigation indicated in , "States [client A] charged taff #1] hit him in the mouth" Il Investigation indicated in #2's/PD #2] statement, "States in PIA (Physical Intervention ing that states a person would in they needed to do to protect they should keep doing their	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DATE DATE		
	#1] struck [client A physical abuse is su], therefore the allegation of bstantiated."					

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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G300		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/11/2022	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 110 W PIKE ST MARTINSVILLE, IN 46151				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤΕ	(X5) COMPLETION DATE
	suspended immedia -The investigation of client A's injuriesThe investigation of to ensure staff was On 8/9/22 at 11:02 Investigation Action "Consult on approp #1] based on invest -There was no correlack of behavior trathe incidentThere was no document arrangement in the -The investigation of action recommenda -There was no corre PD's failing to immedial following the incident -There was no increof the group homeThere was no document arrangement in the group homeThere was no correspondent a	did not include a description of did not address the PD's failure suspended immediately. AM, a review of the 6/17/22 in Response Plan indicated, riate corrective action of [staff igation findings." Detive action addressing the cking or shift notes regarding amentation the seating van was addressed. did not include corrective actions. Detive action addressing the ediately suspend staff #1 and the ediately susp					

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

PRINTED: 09/19/2022 FORM APPROVED OMB NO. 0938-039

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		15G300	B. WI	NG		08/11/	/2022
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIEF	₹			PIKE ST		
TDANGIT	IONAL SERVICES	SUBILC			NSVILLE, IN 46151		
IIVANSII	IONAL SERVICES	SOB LLC		WARTH	13VILLE, IN 40131		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	abrasion on his nos	e as well"					
	0.00000						
		M, a focused review of client					
		ducted. Client A's 12/6/21					
		lan indicated he had a targeted					
		ion toward others (defined as					
	-	g items at others). The plan					
		of (the) client's maladaptive				ļ	
		armful than physical restraint of physical harm to himself or					
		everity of the client's past					
		. The most minimal					
		ies will always be utilized first.					
	_	rvention methods included in					
		rt plan should always be					
		essary, and only after					
		reviously mentioned methods,					
		ive interventions to be utilized.					
		st be exhausted and an					
		the safety of self or others must					
		Indiana Mentor Network					
	-	management. Always begin					
		ctive intervention and proceed					
		-up with the program director or					
		or must be made with-in 15					
		the incident. Staff must contact					
		t within twenty-four hours.					
	_	1 if necessary and only if the					
		ninent threat to the health and					
		ers. The specific physical					
	-	for this individual includes the					
		interventions in the order listed					
		ventions are utilized): Escort					
		de, hand behind, and hand				ļ	
	•	v hand mid back), Releases and					
		eases, Manual One-Arm Hold,				ļ	
		o One Arm Hold, and Two Arm					
	Block to Wrap/One						
	On 8/8/22 at 1:27 P	M, the Quality Improvement					
			1				1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		15G300	B. W	ING		08/11/	2022	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIER				PIKE ST			
TRANSIT	TIONAL SERVICES	SUBLIC			NSVILLE, IN 46151			
TRANSITIONAL SERVICES SUB LLC			WALKTIII	40 VILLE, IIV 40 10 I				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ГЕ	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	Specialist (QIS) ind							
	investigations shoul	-						
		n 5 working days. The QIS						
		ne was working on a separate						
	_	ought the former PD was						
		his investigation. She stated						
	she "got started late	-						
	_	de of the 5 working days."						
		on 5/13/22, staff #1 reported he						
	I -	nt A when something slipped						
		he next day (5/14/22), the						
		client A was not comfortable						
		suspended him. She						
		eported staff #1 hit him so he						
		ispended immediately. The						
		envestigation should have						
	addressed staff #1 n							
	I -	nding. The QIS indicated the						
		ssessed client A's injuries						
		d not request and review the						
		ntation. The QIS indicated buld have been included in the						
		QIS indicated she had a						
		recommendations however it						
		nvestigation. The QIS						
		ot address the lack of						
		ne staff involved regarding the						
		ndicated it should have been						
	1	restigation. The QIS indicated						
		hit client A. The QIS stated						
		was ok. Think he knew he						
	1	I think he was scared of						
		S stated her investigation						
	l	ical abuse." On 8/9/22 at						
		indicated the facility should						
		e clients. The QIS indicated						
	1 ~	licy and procedure prohibiting						
		licated the investigation						
		scription of client A's injuries.						
	She indicated she ha							

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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 <u>00</u>			COMPLETED	
		15G300	B. WING			08/11/2022	
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	8			PIKE ST		
TDANCI	TIONAL SERVICES	SUBILIC			NSVILLE, IN 46151		
TRANSITIONAL SERVICES SUB LLC				WARTIN	NSVILLE, IN 46151		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			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 APPROPRIATION OF THE		ΤF	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	. =	DATE
	information in the p	past and it was never					
	discussed. The QIS	stated it "would be					
	beneficial." The Ql	S stated the investigation was					
	"missing several co	mponents of a thorough					
	investigation." The	QIS indicated although the					
	van seating arrange	ment was addressed in the					
	investigation, there	were no corrective actions					
	included in the inve	estigation to ensure the van					
	seating arrangemen	t was changed. The QIS					
	indicated she was n	ot aware of increased					
	administrative over	sight at the group home					
	following the incide	ent.					
	_						
	On 8/8/22 at 12:40	PM, Program Director #2					
	indicated staff #1 w	ras terminated after an incident					
	with client A. PD #	[‡] 2 indicated staff #1 hit client A					
	and was terminated	for abuse.					
	On 8/9/22 at 12:25	PM, the Regional Director (RD)					
	indicated initially th	ne PD thought staff used PIA					
	causing the injury to	o client A's lips and nose. The					
	RD stated, "It was d	letermined pretty quickly it					
	needed to be treated	l as possible abuse." It was					
		was determined it was abuse.					
	_	punching him and he was					
		e. The RD stated, "It was					
		licated she discussed					
		#1 before the investigation					
		e RD stated, "That was going					
		he RD indicated when she					
		ion and was told the facility					
		hing with staff #1, she was					
		addressed before she					
	_	ion. The RD indicated staff #1					
		ispended immediately. The					
		neframe for reporting the					
		ions to the administration was					
	5 working days. Th]
		ot thorough. The RD					
		y should include additional					
		,					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G300		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/11/2022			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 110 W PIKE ST MARTINSVILLE, IN 46151				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
W 0149	indicated the investi addressed that staff immediately. The F should have include injuries. The RD in documentation the I Response Plan was indicated the investi addressed the lack of the incident by the of home. The RD indi- have addressed the ensure it was compl- was not aware of an oversight at the grot- incident.	#1 was not suspended RD indicated the investigation d a description of client A's dicated there was no nvestigation Action implemented. The RD					
Bldg. 00	written policies an mistreatment, neg Based on record revincident/investigative clients A, C and G, implement its policiabuse of the clients, investigation of staffincident of client to facility-operated day abuse while the inventor the results of reported to the admidays, and take appropriate to the admidays, and take appropriate to the staffincial to	evelop and implement d procedures that prohibit lect or abuse of the client. The reports reviewed affecting the facility neglected to less and procedures to prevent conduct a thorough of abuse of client A and an client aggression at the less y program, prevent further less less than the less tha	W 0149	The QIDP (PD) is no longer was Indiana Mentor as of 8.5.22. record will reflect that she will be re-hirable at Indiana Mentor to a substantiation of neglect stemming from an investigation a different home. She left before corrective action could be taken on the results of the survey findings for this survey. (Specifically recognizing, report and following policy for Abuse Neglect and Exploitation and services of the survey.	Her not or due on in fore en orting		

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SU		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPI		COMPL	ETED	
		15G300	B. WI	NG	<u> </u>	08/11/	2022
				CTDEET A	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
TDANCIT	IONAL CEDVICES	CLIDILLO			PIKE ST NSVILLE, IN 46151		
TRANSITIONAL SERVICES SUB LLC			WARTII	NSVILLE, IIN 46151			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					reporting and investigating clie	ent to	
	Findings include:				client aggression) A New Hire	е	
					checklist has been implemente	ed	
		PM, a review of the facility's			that addresses the rehire eligit	oility	
		ve reports was conducted and			status.		
	indicated the follow	ving:			A PD has been assigned to the	е	
					home to provide oversight and		
		00 PM, client A got upset with			monitoring of individuals, their		
		22 Bureau of Developmental			plans and the home until a nev		
		s (BDDS) incident report			PD (QIDP) is trained (Hired to		
		/22, [client A] got upset with			start 9.12.22). The acting PD v		
	staff, demanding he go on an outing. When he				be retrained on recognizing ar		
	was reminded it wasn't his afternoon to go on an				reporting allegations of ANE.		
	_	ating being scheduled on			new PD (QIDP) will be trained	on	
	_	came verbally and physically			recognizing and reporting		
		staff. He threw and hit staff			allegations of Abuse, Neglect		
	_	ne and kicked a hole in the			Exploitation. The training wil		
	_	en went after staff again			include how to investigate and	а	
		reported he put his arms up to			review of the guidelines for		
		m hitting him and staff			timeliness noted in the Indiana	1	
	_	identally hit [client A] in the is arms and [client A] got hit in			Mentor policy.	اما	
		nd they bled. [Client A] also			The current PD will be retrained		
		e phone at [client G] and hit			and the new PD (QIDP) will be		
		Client A] was checked for			trained on the Supervisor Site review expectations. The		
	_	l up and an ice pack was put			Supervisor Site Review form is	s to	
		G] was checked for injuries as			be turned into the Area Director		
		e and he said he was just sore.			(Regional Director in the absen		
		that staff hit him so staff was			of an AD) monthly to ensure	1.50	
	_	an investigation and to			oversight of the PD.		
		tive action or retraining needs			The QIS was retrained by the		
		Staff will continue to follow			Quality Improvement Manager		
	-	ehavior Support Plan). An			7.26.22. This was after the		
	,	e completed to determine if any			investigation noted in this surv	ey	
	_	eed to be completed and if			was done but before this surve	-	
		eds to be changed for his and			was completed. The	·	
	others' safety."	-			investigations done by the QIS	3	
	•				were reviewed for a period of		
	Staff #1 was susper	nded on 5/14/22 after working			days by either the Ql Manager		
	on 5/13/22 until 10:	26 PM and 5/14/22 from 6:54			another member of the QI tear		
			1		l		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		15G300	B. W	B. WING 08/11/2022			2022
				CTREET	DDDECC CITY CTATE ZID COD		
NAME OF P	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
TDANIGIT	FIONIAL OFFICEO	CLIPILLO			PIKE ST		
TRANSH	TIONAL SERVICES	SUB LLC		MARTIN	NSVILLE, IN 46151		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	AM to 9:26 AM. T	he facility failed to prevent			ensure the investigations done		
	further potential abo	use while an investigation was			were thorough and completed		
	in progress.				within the 5 day time frame.	The	
					Regional Director will monitor	the	
	The 6/27/22 Incider	nt Follow-Up Report indicated,			QIS while completing		
	"The internal inve	estigation was completed and			investigations to ensure the 5	day	
	signed off by the Re	egional Director on 6/17/2022.			time frame is adhered to and v	-	
	From the investigat	ion it was determined the			review the investigation to ens	sure	
	event was substanti	ated. Staff was terminated			it is thorough.		
	effective 6/17/22. S	Staff has not worked in the			Responsible Party: Regional		
	home during the inv	vestigation"			Director		
	The 6/13/22 Internal Investigation indicated in						
	staff #1's statement	client A asked him to go on an					
	outing during the ev	vening shift. Staff #1 told					
	client A he went on	his outing on 5/11/22 and					
	could not go. Clien	t A started hitting the back of					
	the driver's seat in t	he van as well as hitting staff					
		vas driving. Staff #1's statement					
	_	indicated, "States he					
		ing he was told that in a					
	_	al situation you vound (sic)					
		protect yourself States that					
		PD] said that if he couldn't find					
		switch places with [staff #7]					
	' '	ack out on their van ride to get					
		States he asked [PD] about the					
		him coming in the next day and					
	_	him if he wanted to come in.					
		the next morning and was					
		a.m States [former Area					
	_	l him and asked how it was					
		told him (sic) was being					
		because [client A's] parents					
		[client A] said he was					
	uncomfortable with	[staff #1]"					
		Il Investigation indicated in the					
		States [staff #1] called her first					
	after the incident	States he reported he had hit					

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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 08/11/2022			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 110 W PIKE ST MARTINSVILLE, IN 46151				
(X4) ID PREFIX	SUMMARY	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DATE		
	#1] reported he had	ne was rambling. States [staff used PIA (Physical atives) and that [client A] was					
	his grips. States she	he had to hit him to get out of e understood that he had hit					
	intentional States	PIA. That it wasn't [former Area Director]					
	with [client A's] par	on Saturday after speaking rents. States no one took					
		care regarding his nose. know if he was seen by the nose"					
	staff #7's statement,	al Investigation indicated in "States they couldn't find for [staff #1] so he could					
	client C's statement	Il Investigation indicated in , "States [client A] hit [staff it [client A] and he cried"					
	client G's statement	al Investigation indicated in , "States [client A] charged taff #1] hit him in the mouth"					
	[Program Director # there isn't anything Alternatives) training need to do whateve	al Investigation indicated in #2's/PD #2] statement, "States in PIA (Physical Intervention ng that states a person would rethey needed to do to protect					
	holds and their bloc						
	Conclusions of Fact discrepancy regarding house at the time of supports that there	Il Investigation indicated in the t section, "Evidence supports ng who was present at the the incident. Evidence was no Behavior Tracking ce supports there were no shift					

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PRINTED: 09/19/2022 FORM APPROVED

CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039	
	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 B. WING				(X3) DATE SURVEY COMPLETED 08/11/2022	
	PROVIDER OR SUPPLIE		110 W	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE CO	(X5) MPLETION DATE
	notes completed re specifically. Evide grabbed [staff #1]. A] created a hazard group home van. If #1] struck [client A physical abuse is startly phy	garding this incident ence supports that [client A] Evidence supports that [client dous driving situation in the Evidence supports that [staff A], therefore the allegation of substantiated." did not address staff was not ately. did not include a description of did not address the PD's failure suspended immediately. AM, a review of the 6/17/22 on Response Plan indicated, oriate corrective action of [staff tigation findings." rective action addressing the acking or shift notes regarding van was addressed. did not include corrective actions. rective action addressing the nediately suspend staff #1 lent. eased administrative oversight				

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picture of himself from 5/13/22. Client A's lower and top lips were swollen on the left side. Both his top and lower lips were purple, blue and red.

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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. BUILDING <u>00</u> COMPLETE.			ETED	
		15G300	B. W	ING		08/11/	/2022
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	2					
TDANCIT	TIONIAL SERVICES	SUBLIC			PIKE ST		
TRANSITIONAL SERVICES SUB LLC			WARTII	NSVILLE, IN 46151			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG DEFICIENCY)		DATE	
	Client A had blood	in the corners of his mouth.					
	Client A's nostrils were bloody.						
	On 8/9/22 at 11:02 AM, a review of the 5/20/22						
		stigation Narrative section					
	_	I observed [client A] to have					
		op and bottom and also (sic)					
	abrasion on his nose	e as well"					
		M, a focused review of client					
		ducted. Client A's 12/6/21					
		lan indicated he had a targeted					
		ion toward others (defined as					
		g items at others). The plan					
		of (the) client's maladaptive					
		armful than physical restraint					
		of physical harm to himself or					
		everity of the client's past					
		. The most minimal					
	_	ies will always be utilized first.					
		rvention methods included in					
		rt plan should always be					
		essary, and only after					
		reviously mentioned methods,					
		ive interventions to be utilized.					
		st be exhausted and an the safety of self or others must					
		Indiana Mentor Network					
		management. Always begin					
		ctive intervention and proceed					
		-up with the program director or					
		or must be made with-in 15					
	1	he incident. Staff must contact					
	_	t within twenty-four hours.					
	I	1 if necessary and only if the					
		ninent threat to the health and					
		ers. The specific physical					
	· ·	for this individual includes the					
		interventions in the order listed					
	_	ventions are utilized): Escort					
	(omy checked inter	ventions are utilized). Escort					

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

PRINTED: 09/19/2022 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	(X2) MUL A. BUIL B. WING	DING	nstruction <u>00</u>	(X3) DATE : COMPL 08/11/	ETED
		130300	<u> </u>			00/11/	2022
NAME OF F	PROVIDER OR SUPPLIER	8		STREET A 110 W F	DDRESS, CITY, STATE, ZIP COD		
TRANSIT	TIONAL SERVICES	SUB LLC			ISVILLE, IN 46151		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
		de, hand behind, and hand					
		w hand mid back), Releases and eases, Manual One-Arm Hold,					
	· ·	o One Arm Hold, and Two Arm					
	Block to Wrap/One						
	Bioon to wrap one	11111111111111					
	On 8/8/22 at 1:27 P	M, the Quality Improvement					
	Specialist (QIS) ind	licated the results of					
	investigations should	ld be reported to the					
		n 5 working days. The QIS					
		he was working on a separate					
	-	ought the former PD was					
		his investigation. She stated					
	-	and completed the					
	-	de of the 5 working days." on 5/13/22, staff #1 reported he					
		nt A when something slipped					
		he next day (5/14/22), the					
		I client A was not comfortable					
		suspended him. She					
		eported staff #1 hit him so he					
	should have been su	aspended immediately. The					
	QIS indicated her in	nvestigation should have					
	addressed staff #1 r						
	-	nding. The QIS indicated the					
		ssessed client A's injuries					
	-	d not request and review the					
		ntation. The QIS indicated					
		ould have been included in the QIS indicated she had a					
		recommendations however it					
		investigation. The QIS					
	_	ot address the lack of					
		he staff involved regarding the					
	-	indicated it should have been					
	,	vestigation. The QIS indicated					
		hit client A. The QIS stated					
		was ok. Think he knew he					
		I think he was scared of					
	[client A]." The QI	S stated her investigation					

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		15G300	B. WI	NG		08/11/2022	
NAME OF D	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
					PIKE ST		
TRANSIT	TIONAL SERVICES	SUB LLC		MARTIN	NSVILLE, IN 46151		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA [*] DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION ical abuse." On 8/9/22 at		TAG	DEFICIENCE		DATE
		indicated the facility should					
		e clients. The QIS indicated					
	-	licy and procedure prohibiting					
		icated the investigation					
	should include a des	scription of client A's injuries.					
	She indicated she ha						
	information in the p						
	discussed. The QIS						
		S stated the investigation was mponents of a thorough					
	-	QIS indicated although the					
	-	ment was addressed in the					
		was no corrective actions					
		stigation to ensure the van					
	seating arrangemen	t was changed. The QIS					
		ot aware of increased					
		sight at the group home					
	following the incide	ent.					
	On 8/8/22 at 12:40	PM, Program Director #2					
	indicated staff #1 w	as terminated after an incident					
	with client A. PD#	2 indicated staff #1 hit client A					
	and was terminated	for abuse.					
	On 8/9/22 at 12:25	PM, the Regional Director (RD)					
		ne PD thought staff used PIA					
		o client A's lips and nose. The					
		letermined pretty quickly it					
		l as possible abuse." It was					
	investigated and it v	vas determined it was abuse.					
		punching him and he was					
		e. The RD stated, "It was					
		icated she discussed					
		#1 before the investigation e RD stated, "That was going					
	_	ne RD indicated when she					
		ion and was told the facility					
		hing with staff #1, she was					
		addressed before she					
			1				

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED		
		15G300	B. W	B. WING			08/11/2022	
			<u> </u>	CTREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIER	8						
TDANIOI	FIONIAL OFFINIOFO	CLIPILLO			PIKE ST			
TRANSII	TIONAL SERVICES	SUB LLC		MARIII	NSVILLE, IN 46151			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDENCE NAME OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	ICY 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 OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE	
	returned from vacat	tion. The RD indicated staff #1						
		ispended immediately. The						
		neframe for reporting the						
		ions to the administration was						
	5 working days. Th							
		ot thorough. The RD						
		y should include additional						
		nvestigation. The RD						
		igation should have						
		#1 was not suspended						
		RD indicated the investigation						
	· ·	ed a description of client A's						
		ndicated there was no						
	1 -	Investigation Action						
		implemented. The RD						
	_	igation should have						
		of documentation regarding						
		direct care staff at the group						
	1	icated the investigation should						
		van seating arrangement to						
		leted. The RD indicated she						
	_	ny increased administrative						
		up home following the						
	incident.	up nome following the						
	merdent.							
	2) On 5/23/22 of 1.	30 PM at the facility operated						
		e peer hit client C with an open						
		eft side of his face. Client C						
		he left side of his face.						
	nau a reu mark on t	ne left side of his face.						
	There was no doou	mentation the facility						
	conducted an invest							
	conducted an invest	uganon.						
	On 8/8/22 at 2.21 D	M, the day program Program						
		she did not conduct an						
		incident. The PD indicated an						
	_	d have been conducted. The						
		igh she interviewed the staff						
		ot interview the clients						
	present.							

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

PRINTED: 09/19/2022 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		15G300	B. WI	NG		08/11/2022	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIEF	R			PIKE ST		
TRANSIT	IONAL SERVICES	SUBLIC			NSVILLE, IN 46151		
	TOTAL GENTIGES			WW (I CITI	101111		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	0.0/0/2210.10						
		AM, a review of the facility's					
	-	uality and Risk Management					
	-	ed. The policy indicated, "1) promotes a high quality of					
		promotes a high quanty of protect individuals receiving					
		services through oversight of					
		dures and company operations,					
		Service delivery and through a					
	_	ng, evaluating and reducing					
		duals are exposed 2) Indiana					
		the BDDS Incident Reporting					
		n the Provider Standards. An					
		as follows shall be reported to					
		ncident report form prescribed					
	by the BDDS: 1. A	Alleged, suspected, or actual					
	abuse, neglect, or e	xploitation of an individual. An					
	incident in this cate	gory shall also be reported to					
	Adult Protective Se	rvices or Child Protective					
		ble. The provider shall					
	_	ved in an incident from duty					
		on by the provider. This may					
	-	buse, including but not limited					
	-	sching another person in a					
		ngry manner; Willful infliction					
		otional/verbal abuse, including					
		ommunicating with words or					
	•	s presence Failure to					
		supervision, care or training					
		is committed to completing a					
		ion for any event out of the					
		pardizes the health and safety erved or other employee					
	i i	be completed for all deaths,					
		e, neglect, exploitation or					
	-	itional investigations will be					
		lents with significant injuries of					
	-	d incidents that may be					
	requested by outsid						
	1						
			1				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUIL	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/11/2022		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 110 W PIKE ST MARTINSVILLE, IN 46151				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PR	ID REFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
W 0154	9-3-2(a)	ates to complaint #IN00384168.					
	483.420(d)(3) STAFF TREATME						
Bldg. 00	alleged violations Based on record revincident/investigative clients A, C and G, thorough investigative and an incident of centre facility-operated. Findings include: On 8/8/22 at 12:46 incident/investigative indicated the follow. 1) On 5/13/22 at 4: staff #1. The 5/14/2 Disabilities Services indicated, "On 5/13 staff, demanding he was reminded it was outing due to his ou Wednesdays, he becaggressive toward s with the house phor dining room. He the physically and staff block [client A] from self-reported he acce face when raising he	PM, a review of the facility's we reports was conducted and ring: 00 PM, client A got upset with 22 Bureau of Developmental s (BDDS) incident report /22, [client A] got upset with 29 on an outing. When he son't his afternoon to go on an uting being scheduled on came verbally and physically taff. He threw and hit staff he and kicked a hole in the en went after staff again reported he put his arms up to m hitting him and staff identally hit [client A] in the is arms and [client A] got hit in	W 015	54	The QIDP (PD) is no longer will indiana Mentor as of 8.5.22. I record will reflect that she will be re-hirable at Indiana Mentot of a substantiation of neglect stemming from an investigation a different home. She left before corrective action could be taken on the results of the survey findings for this survey. (Specifically recognizing, reporting and Exploitation and a reporting and investigating client aggression). A New Hir checklist has been implement that addresses the rehire eliginates. A PD has been assigned to the home to provide oversight and monitoring of individuals, their plans and the home until a ne PD (QIDP) is trained (Hired to start 9.12.22). The acting PD be retrained on recognizing an reporting ANE. The new PD (Civilla be trained on recognizing reporting allegations of Abuse	Her not or due on in fore en orting e, also ent to be ed bility as directly will and QIDP) and e,	09/10/2022
	threw another house him in the back. [C	ad they bled. [Client A] also be phone at [client G] and hit client A] was checked for lup and an ice pack was put			Neglect and Exploitation. The training will include how to investigate and a review of the guidelines for timeliness note.	е	

09/19/2022 PRINTED: DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-039 X3) DATE SURVEY STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 08/11/2022 15G300 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 110 W PIKE ST MARTINSVILLE, IN 46151 TRANSITIONAL SERVICES SUB LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE on his lip. [Client G] was checked for injuries as the Indiana Mentor policy. well and found none and he said he was just sore. The current PD will be retrained [Client A] reported that staff hit him so staff was and the new PD (QIDP) will be suspended pending an investigation and to trained on the Supervisor Site determine if corrective action or retraining needs review expectations. The to be completed... Staff will continue to follow Supervisor Site Review form is to [client A's] BSP (Behavior Support Plan). An be turned into the Area Director investigation will be completed to determine if any (Regional Director in the absence corrective actions need to be completed and if of an AD) monthly to ensure [client A's] BSP needs to be changed for his and oversight of the PD. others' safety." The QIS was retrained by the Quality Improvement Manager on The 6/13/22 Internal Investigation indicated in 7.26.22. This was after the staff #1's statement client A asked him to go on an investigation noted in this survey outing during the evening shift. Staff #1 told was done but before this survey

client A he went on his outing on 5/11/22 and could not go. Client A started hitting the back of the driver's seat in the van as well as hitting staff #1's arm while he was driving. Staff #1's statement in the investigation indicated, "...States he thought that in training he was told that in a dangerous behavioral situation you vound (sic) defend yourself to protect yourself... States that [Program Director/PD] said that if he couldn't find someone he should switch places with [staff #7] and take the guys back out on their van ride to get out of the house... States he asked [PD] about the protocol regarding him coming in the next day and she said it was up to him if he wanted to come in. States he showed up the next morning and was there until about 11 a.m... States [former Area Director/AD] called him and asked how it was going. States [AD] told him (sic) was being suspended with pay because [client A's] parents informed them that [client A] said he was

was completed. The investigations done by the QIS were reviewed for a period of 30 days by either the QI Manager or another member of the QI team to ensure the investigations done were thorough and completed within the 5 day time frame. The Regional Director will monitor the QIS while completing investigations to ensure the 5 day time frame is adhered to and will review the investigation to ensure it is thorough. Responsible Party: Regional Director

The 6/13/22 Internal Investigation indicated in the PD's statement, "...States [staff #1] called her first after the incident... States he reported he had hit

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uncomfortable with [staff #1]...."

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		15G300	B. W	ING		08/11/2022	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER				PIKE ST		
TRANSIT	TIONAL SERVICES	SUB LLC			NSVILLE, IN 46151		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID I			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ie	DATE
	[client A] and that h	e was rambling. States [staff					
	#1] reported he had	used PIA (Physical					
	Intervention Alterna	ntives) and that [client A] was					
	coming at him and l	ne had to hit him to get out of					
	his grips. States she	e understood that he had hit					
	_	PIA. That it wasn't					
		[former Area Director]					
		on Saturday after speaking					
		ents. States no one took					
		care regarding his nose.					
		know if he was seen by the					
	nurse regarding his	nose"					
	The 6/13/22 Interna	l Investigation indicated in					
		"States they couldn't find					
		for [staff #1] so he could					
	leave."	or [starr #1] so he could					
	100.701						
	The 6/13/22 Interna	l Investigation indicated in					
	client C's statement,	"States [client A] hit [staff					
	#1] and [staff #1] hi	t [client A] and he cried"					
	Th - (/12/22 Int	l Investigation indicated in					
		, "States [client A] charged					
		taff #1] hit him in the mouth"					
	[Starr #1]. States [St	and the mountain					
	The 6/13/22 Interna	l Investigation indicated in					
		[‡] 2's/PD #2] statement, "States					
		in PIA (Physical Intervention					
		g that states a person would					
	need to do whatever	they needed to do to protect					
	themselves. States	they should keep doing their					
	holds and their bloc	ks."					
	The 6/12/22 I	1 Impropriantion in direct - 4 in the					
		l Investigation indicated in the					
		section, "Evidence supports ng who was present at the					
		the incident. Evidence					
		vas no Behavior Tracking					
		ce supports there were no shift					
	I simpleted. Eviden	22 Supports there were no sinit				I	

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIP	LE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDI	NG	00	COMPLETED	
		15G300	The state of the s			08/11/	2022
			Larr	NEET 4	DDDEGG CHTV CTATE JID COD		
NAME OF I	PROVIDER OR SUPPLIER	₹			DDRESS, CITY, STATE, ZIP COD		
TDANIOIT	FIGNIAL OFFICEO	OUD II O			PIKE ST		
IRANSII	FIONAL SERVICES	SUB LLC	IVIA	AKIIN	ISVILLE, IN 46151		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREF	ΊΧ	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	G	DEFICIENCY)		DATE
	notes completed reg	garding this incident					
	specifically. Eviden	nce supports that [client A]					
	grabbed [staff #1].	Evidence supports that [client					
	A] created a hazard	ous driving situation in the					
	group home van. E	vidence supports that [staff					
	#1] struck [client A], therefore the allegation of					
	physical abuse is su	ıbstantiated."					
	_	did not address staff was not					
	suspended immedia	•					
	_	did not include a description of					
	client A's injuries.	111 . 11					
	_	did not address the PD's failure					
	to ensure staff was	suspended immediately.					
	On 8/8/22 at 3:26 P	M, client A sent the surveyor a					
		from 5/13/22. Client A's lower					
	_	wollen on the left side. Both					
		ps were purple, blue and red.					
		in the corners of his mouth.					
	Client A's nostrils v						
		•					
		M, the Quality Improvement					
		licated her investigation should					
		f#1 not being suspended					
	-	nding. The QIS indicated the					
		ssessed client A's injuries					
		d not request and review the					
	assessment docume	entation. The QIS indicated					
	this information sho	ould have been included in the					
	investigation. The	QIS indicated she had a					
	document with the	recommendations however it					
	_	investigation. The QIS					
		ot address the lack of					
	_	he staff involved regarding the					
	`	indicated it should have been					
		vestigation. On 8/9/22 at 12:25					
		ted the investigation should					
	include a descriptio	on of client A's injuries. She					
	indicated she had no	ot included this information in					

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Event ID:

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	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA		ľ		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15G300	A. BU B. W	JILDING ING	00	. COMPLETED 08/11/2022	
		100000	D. W	_		00/11/	LULL
NAME OF P	ROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD		
TRANSIT	TIONAL SERVICES	SUB LLC			NSVILLE, IN 46151		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY		DATE
	-	never discussed. The QIS beneficial." The QIS stated					
	the investigation wa	-					
	-	orough investigation."					
	•						
		PM, the Regional Director (RD)					
		igation was not thorough.					
		he facility should include					
		ion in the investigation. The vestigation should have					
		#1 was not suspended					
		RD indicated the investigation					
	•	ed a description of client A's					
	injuries. The RD in	ndicated the investigation					
		sed the lack of documentation					
		ent by the direct care staff at					
	the group home. The						
	-	d have addressed the van to ensure it was completed.					
	scatting arrangement	t to ensure it was completed.					
	2) On 5/23/22 at 1:	30 PM at the facility operated					
		e peer hit client C with an open					
	hand twice on the le	eft side of his face. Client C					
	had a red mark on t	he left side of his face.					
	T1 1						
	There was no docur	mentation the facility					
	conducted an invest	ugauon.					
	On 8/8/22 at 2:21 P	M, the day program Program					
		she did not conduct an					
	investigation of the	incident. The PD indicated an					
		d have been conducted. The					
		igh she interviewed the staff					
	•	ot interview the clients					
	present.						
	This federal tag rela	ates to complaint #IN00384168.					
	9-3-2(a)						
	1		ı				

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l í		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COMPLE			ETED
		15G300	B. WING 08/11/2022			2022	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 110 W PIKE ST MARTINSVILLE, IN 46151				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID				(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION			IE	DATE	
TAG W 0155 Bldg. 00	483.420(d)(3) STAFF TREATME The facility must p abuse while the in Based on record rev incident/investigativ clients A and G, the further potential abu group home by faili immediately follow abuse. Findings include: On 8/8/22 at 12:46 li incident/investigativ indicated the follow On 5/13/22 at 4:00 li staff #1. The 5/14/2 Disabilities Services indicated, "On 5/13, staff, demanding he was reminded it was outing due to his ou Wednesdays, he beca aggressive toward s with the house phore dining room. He the physically and staff block [client A] from self-reported he acc face when raising hi (sic) lip and nose an threw another house him in the back. [Client Cl well and found none will self-client Cl well and found none	ent of CLIENTS revent further potential vestigation is in progress. riew and interview for 1 of 5 re reports reviewed affecting facility failed to prevent use of the clients living at the ng to suspend staff #1 ing an allegation of physical PM, a review of the facility's re reports was conducted and	W	TAG	The QIDP (PD) is no longer we Indiana Mentor as of 8.5.22. It record will reflect that she will be re-hirable at Indiana Mentor to a substantiation of neglect stemming from an investigation a different home. She left before corrective action could be taken on the results of the survey findings for this survey. (Specifically recognizing, reporting and investigating cliectlient aggression). A New Him checklist has been implemented that addresses the rehire eligit status. A PD has been assigned to the home to provide oversight and monitoring of individuals, their plans and the home until a new PD (QIDP) is trained (Hired to start 9.12.22). The acting PD will be retrained on recognizing arreporting ANE. The new PD (Civil be trained on recognizing arreporting allegations of Abuse Neglect and Exploitation. The training will include how to investigate and a review of the guidelines for timeliness noted the Indiana Mentor policy. The current PD will be retrained and the new PD (QIDP) will be trained on the Supervisor Site	ith Her not bridge and in ore en orting en	DATE 09/10/2022

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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. BUILDING <u>00</u>			COMPLETED	
		15G300	B. WING 08/11/2022			2022	
				·			
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
					PIKE ST		
TRANSITIONAL SERVICES SUB LLC			MARTIN	NSVILLE, IN 46151			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			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 OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	suspended pending	an investigation and to			review expectations. The		
	determine if correct	tive action or retraining needs			Supervisor Site Review form is	s to	
	to be completed S	Staff will continue to follow			be turned into the Area Directo	or	
	[client A's] BSP (Be	ehavior Support Plan). An			(Regional Director in the abse	nce	
	investigation will be	e completed to determine if any			of an AD) monthly to ensure		
	corrective actions n	eed to be completed and if			oversight of the PD.		
		eds to be changed for his and			The QIS was retrained by the		
	others' safety."	-			Quality Improvement Manager		
	_				7.26.22. This was after the		
	Staff #1 was susper	nded on 5/14/22 after working			investigation noted in this surv	ey	
	on 5/13/22 until 10:	:26 PM and 5/14/22 from 6:54			was done but before this surve	-	
	AM to 9:26 AM. T	he facility failed to prevent			was completed. The		
	further potential abo	use while an investigation was			investigations done by the QIS	3	
	in progress.				were reviewed for a period of	30	
					days by either the QI Manage	ror	
	The 6/13/22 Interna	al Investigation indicated in			another member of the QI teal	m to	
	staff #1's statement,	, "States that [Program			ensure the investigations done	e	
	Director/PD] said th	nat if he couldn't find someone			were thorough and completed		
	he should switch pl	aces with [staff #7] and take			within the 5 day time frame.	The	
	the guys back out o	n their van ride to get out of			Regional Director will monitor	the	
	the house States	he asked [PD] about the			QIS while completing		
	protocol regarding	him coming in the next day and			investigations to ensure the 5	day	
	she said it was up to	him if he wanted to come in.			time frame is adhered to and v	will	
	States he showed up	p the next morning and was			review the investigation to ens	sure	
	there until about 11	a.m States [former Area			it is thorough.		
	Director/AD] called	l him and asked how it was			Responsible Party: Regional		
		told him (sic) was being			Director		
		because [client A's] parents					
		[client A] said he was					
	uncomfortable with	[staff #1]"					
	Th - (/12/22 I /	d Tourness and in the district of					
		al Investigation indicated in the					
		States [staff #1] called her first					
		States he reported he had hit					
		ne was rambling. States [staff					
		used PIA (Physical					
		atives) and that [client A] was					
	_	he had to hit him to get out of					
		e understood that he had hit					
	him while using the	e PIA. That it wasn't	1				

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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 08/11/2022
	PROVIDER OR SUPPLIER TONAL SERVICES SUB LLC	110 W	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	intentional States [former Area Director] suspended [staff #1] on Saturday after speaking with [client A's] parents. States no one took [client A] to urgent care regarding his nose. States she does not know if he was seen by the nurse regarding his nose" The 6/13/22 Internal Investigation indicated in staff #7's statement, "States they couldn't find anyone to come in for [staff #1] so he could leave." The 6/13/22 Internal Investigation indicated in [Program Director #2's/PD #2] statement, "States there isn't anything in PIA training that states a person would need to do whatever they needed to do to protect themselves. States they should keep doing their holds and their blocks." On 8/8/22 at 1:27 PM, the Quality Improvement Specialist (QIS) indicated client A reported staff #1 hit him so he should have been suspended immediately. On 8/9/22 at 12:25 PM, the Regional Director (RD) indicated staff #1 should have been suspended immediately. This federal tag relates to complaint #IN00384168.			
W 0156	483.420(d)(4) STAFF TREATMENT OF CLIENTS			
Bldg. 00	The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 1 of 5	W 0156	The QIDP (PD) is no longer w	ith 09/10/2022

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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	ЛLDING	00	COMPL	ETED
		15G300	B. W	ING		08/11/	/2022
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
TDANCI	FIONIAL OFFINIOFS	S CLID LL C			PIKE ST		
TRANSI	FIONAL SERVICES	S SUB LLC		WARTII	NSVILLE, IN 46151		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	incident/investigati	ve reports reviewed affecting			Indiana Mentor as of 8.5.22.	Her	
		e facility failed to ensure the			record will reflect that she will	not	
		igation were reported to the			be re-hirable at Indiana Mento	or due	
	administrator withi	n 5 working days.			to a substantiation of neglect		
					stemming from an investigation	on in	
	Findings include:				a different home. She left bef	fore	
	On 8/8/22 at 12:46 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 5/13/22 at 4:00 PM, client A got upset with staff #1. The 5/14/22 Bureau of Developmental Disabilities Services (BDDS) incident report				corrective action could be take	en	
					on the results of the survey		
					findings for this survey.		
					(Specifically recognizing, repo	-	
					and following policy for Abuse	€,	
					Neglect and Exploitation and		
					reporting and investigating cli		
					client aggression) A New Hir		
		3/22, [client A] got upset with			checklist has been implement	ted	
	_	e go on an outing. When he			that addresses the rehire eligi	ibility	
		asn't his afternoon to go on an			status.		
	_	uting being scheduled on			A PD has been assigned to th		
	-	came verbally and physically			home to provide oversight and		
		staff. He threw and hit staff			monitoring of individuals, their		
	_	ne and kicked a hole in the			plans and the home until a ne		
	_	nen went after staff again			PD (QIDP) is trained (Hired to		
		f reported he put his arms up to			start 9.12.22). The acting PD		
		om hitting him and staff			be retrained on recognizing a		
	_	cidentally hit [client A] in the			reporting ANE The new PD (C		
	_	nis arms and [client A] got hit in			will be trained on recognizing		
		nd they bled. [Client A] also			reporting allegations of Abuse		
		e phone at [client G] and hit			Neglect and Exploitation. Th	ne	
	_	Client A] was checked for			training will include how to		
		d up and an ice pack was put			investigate and a review of the		
		G] was checked for injuries as			guidelines for timeliness noted	d in	
		he and he said he was just sore.			the Indiana Mentor policy.		
		that staff hit him so staff was			The current PD will be retrained		
		an investigation and to			and the new PD (QIDP) will be		
		tive action or retraining needs			trained on the Supervisor Site	;	
	_	Staff will continue to follow			review expectations. The		
		ehavior Support Plan). An			Supervisor Site Review form i		
		be completed to determine if any			be turned into the Area Direct		
		need to be completed and if			(Regional Director in the abse	ence	
	[client A's] BSP ne	eds to be changed for his and	1		of an AD) monthly to ensure		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		15G300	B. W	ING		08/11/	/2022
				·		<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
TDANIOI	FIONIAL OFFINIOF	0.0115.11.0			PIKE ST		
TRANSII	FIONAL SERVICES	S SUB LLC		MARIII	NSVILLE, IN 46151		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΔTF	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	others' safety."				oversight of the PD.		
					The QIS was retrained by the	<u> </u>	
	The 6/27/22 Incide	nt Follow-Up Report indicated,			Quality Improvement Manage		
	"The internal inv	estigation was completed and			7.26.22. This was after the		
	signed off by the R	egional Director on 6/17/2022.			investigation noted in this sur	vey	
	From the investigat	From the investigation it was determined the			was done but before this surv	еу	
	event was substantiated. Staff was terminated				was completed. The		
	effective 6/17/22.	Staff has not worked in the			investigations done by the QI	S	
	home during the in	vestigation"			were reviewed for a period of	30	
					days by either the QI Manage	r or	
	The 6/13/22 Internal Investigation indicated in				another member of the QI tea	m to	
	staff #1's statement client A asked him to go on an				ensure the investigations don	е	
	outing during the evening shift. Staff #1 told				were thorough and completed	j	
	client A he went on his outing on 5/11/22 and				within the 5 day time frame.	The	
	_	nt A started hitting the back of			Regional Director will monitor	the	
		the van as well as hitting staff			QIS while completing		
		was driving. Staff #1's statement			investigations to ensure the 5	day	
		indicated, "States he			time frame is adhered to and	will	
	_	ning he was told that in a			review the investigation to en	sure	
	_	ral situation you vound (sic)			it is thorough.		
		protect yourself States that			Responsible Party: Regional		
		PD] said that if he couldn't find			Director		
		switch places with [staff #7]					
		back out on their van ride to get					
		States he asked [PD] about the					
	1	him coming in the next day and					
	_	o him if he wanted to come in.					
		p the next morning and was					
		a.m States [former Area					
	_	d him and asked how it was					
		told him (sic) was being					
		y because [client A's] parents					
		[client A] said he was					
	uncomfortable with	1 [81411 #1]					
	The 6/13/22 Interna	al Investigation indicated in the					
		et section, "Evidence supports					
		ing who was present at the					
		f the incident. Evidence					1
		was no Behavior Tracking					

	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 15G300 B. WING			(X3) DATE SURVEY COMPLETED 08/11/2022			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 110 W PIKE ST MARTINSVILLE, IN 46151				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	(X5) COMPLETION DATE
	notes completed reg specifically. Evider grabbed [staff #1]. A] created a hazard group home van. E #1] struck [client A physical abuse is su On 8/8/22 at 1:27 P Specialist (QIS) indinvestigations shoul administrator within On 8/9/22 at 12:25 indicated the timefr investigations to the days.	M, the Quality Improvement licated the results of ld be reported to the					
W 0157 Bldg. 00	483.420(d)(4) STAFF TREATME If the alleged viola corrective action r	ition is verified, appropriate					
	incident/investigative clients A and G, the appropriate correcti	view and interview for 1 of 5 we reports reviewed affecting e facility failed to ensure ve actions were implemented utiated allegation of abuse	WO	157	The QIDP (PD) is no longer w Indiana Mentor as of 8.5.22. I record will reflect that she will be re-hirable at Indiana Mento to a substantiation of neglect stemming from an investigatio a different home. She left before	Her not r due n in ore	09/10/2022
		PM, a review of the facility's we reports was conducted and ving:			on the results of the survey findings for this survey. (Specifically recognizing, repo and following policy for Abuse Neglect and Exploitation and a	,	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
AND PLAN	OF CORRECTION	15G300	B. WING	00	08/11/2022
		136300	_		00/11/2022
NAME OF E	PROVIDER OR SUPPLIEF	3		ADDRESS, CITY, STATE, ZIP COD	
				PIKE ST	
TRANSIT	FIONAL SERVICES	SUB LLC	MARTI	NSVILLE, IN 46151	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	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 DEFICIENCY)	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	On 5/13/22 at 4:00	PM, client A got upset with		reporting and investigating clie	ent to
	staff #1. The 5/14/2	22 Bureau of Developmental		client aggression) A New Hir	е
	Disabilities Service	es (BDDS) incident report		checklist has been implement	ed
		/22, [client A] got upset with		that addresses the rehire eligi	bility
		e go on an outing. When he		status.	
		sn't his afternoon to go on an		A PD has been assigned to th	e
		iting being scheduled on		home to provide oversight and	
		came verbally and physically		monitoring of individuals, their	
		staff. He threw and hit staff		plans and the home until a ne	•
		ne and kicked a hole in the		PD (QIDP) is trained (Hired to	•
	_	en went after staff again		start 9.12.22). The acting PD	•
		reported he put his arms up to		be retrained on recognizing ar	
		m hitting him and staff		reporting ANE The new PD (C	′ I
	_	eidentally hit [client A] in the		will be trained on recognizing	
	_	is arms and [client A] got hit in		reporting allegations of Abuse	
		nd they bled. [Client A] also		Neglect and Exploitation. Th	ie
		e phone at [client G] and hit		training will include how to	
		Client A] was checked for		investigate and a review of the	•
		d up and an ice pack was put		guidelines for timeliness noted	d in
		G] was checked for injuries as		the Indiana Mentor policy.	
		e and he said he was just sore.		The current PD will be retrained	
		that staff hit him so staff was		and the new PD (QIDP) will be	•
		an investigation and to		trained on the Supervisor Site	
		tive action or retraining needs		review expectations. The	- 4-
	_	Staff will continue to follow ehavior Support Plan). An		Supervisor Site Review form is	
		e completed to determine if any		be turned into the Area Director	
	_	eed to be completed and if		(Regional Director in the abse of an AD) monthly to ensure	IIICE
		eds to be changed for his and		oversight of the PD.	
	others' safety."	cas to be changed for his and		The QIS was retrained by the	,
	omers salety.			Quality Improvement Manage	
	The 6/13/22 Interns	al Investigation indicated in the		7.26.22. This was after the	
		t section, "Evidence supports		investigation noted in this surv	/ev
		ing who was present at the		was done but before this surve	•
		f the incident. Evidence		was completed. The	-,
		was no Behavior Tracking		investigations done by the QIS	3
		ce supports there were no shift		were reviewed for a period of	
		garding this incident		days by either the QI Manage	
		nce supports that [client A]		another member of the QI tea	•
		Evidence supports that [client		ensure the investigations done	
	1 ~	1.1 L	1		•

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	ETED
		15G300	B. W	ING		08/11/	2022
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	2			PIKE ST		
TDANCI	TIONAL SERVICES	SUBLIC			NSVILLE, IN 46151		
IKANSII	IONAL SERVICES	SUB LLC		WARTII	15 VILLE, IIN 46 15 I		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	A] created a hazard	ous driving situation in the			were thorough and completed		
	group home van. E	vidence supports that [staff			within the 5 day time frame.	The	
	#1] struck [client A], therefore the allegation of				Regional Director will monitor	the	
	physical abuse is substantiated." On 8/9/22 at 11:02 AM, a review of the 6/17/22				QIS while completing		
					investigations to ensure the 5	day	
					time frame is adhered to and v	vill	
	Investigation Action Response Plan indicated,				review the investigation to ens	ure	
	"Consult on appropriate corrective action of [staff				it is thorough.		
	#1] based on investigation findings."				Responsible Party: Regional		
					Director		
	-The investigation did not include corrective						
	action recommendations.						
	-There was no corrective action addressing the						
	lack of behavior tracking or shift notes regarding						
	the incident.						
		mentation the seating					
	arrangement in the						
		ective action addressing the					
	_	ediately suspend staff #1					
	following the incide						
		eased administrative oversight					
	of the group home.						
		mentation indicating what					
	corrective action wa	as taken with staff #1.					
	0.000						
		M, client A sent the surveyor a					
	_	rom 5/13/22. Client A's lower					
		vollen on the left side. Both					
		ps were purple, blue and red.					
		in the corners of his mouth.					
	Client A's nostrils v	vere bloody.					
	O., 9/9/22 -4 1.27 D	M 4h - O1' I					
		M, the Quality Improvement					
		licated she had a document					
		dations however it was not part On 8/9/22 at 12:25 PM, the					
	QIS indicated altho	-					
	_	Idressed in the investigation,					
		ctive actions included in the					
	investigation to ens	ure me van seanng	1				

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COM		(X3) DATE SURVEY COMPLETED 08/11/2022		
	PROVIDER OR SUPPLIER		110 W	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	was not aware of in oversight at the ground incident. On 8/9/22 at 12:25 indicated there was Investigation Action implemented. The saware of any increathe group home follows:	anged. The QIS indicated she creased administrative up home following the PM, the Regional Director (RD) no documentation the Response Plan was RD indicated she was not sed administrative oversight at owing the incident. tes to complaint #IN00384168.			
W 0159 Bldg. 00	be integrated, coo a qualified intellect who-Based on record revolutions in the sample Intellectual Disability Program Director), and monitor the clie group home. The Quallegation of physic were taken to ensure the course of an invensure staff docume behavior tracking an failed to ensure there implemented follow abuse at the group been sure the van seating addressed following to ensure client B has	e treatment program must rdinated and monitored by tual disability professional riew and interview for 3 of 3 e (A, B and C), the Qualified ties Professional (QIDP/called failed to integrate, coordinate ents' program plans at the PIDP failed to recognize an all abuse and ensure steps e the clients were safe during estigation. The QIDP failed to ented the incident in client A's and shift notes. The QIDP was administrative oversight ring the allegation of physical tome. The QIDP failed to an arrangement was the incident. The QIDP failed and a plan to address pulling a client C had a plan to	W 0159	The QIDP (PD) is no longer was Indiana Mentor as of 8.5.22. record will reflect that she will be re-hirable at Indiana Mentor to a substantiation of neglect stemming from an investigation a different home. She left before corrective action could be take on the results of the survey findings for this survey. (Specifically recognizing, reporting and following policy for Abuse Neglect and Exploitation and reporting and investigating clicitent aggression). A New Hir checklist has been implement that addresses the rehire eligit status.	Her not or due on in fore en orting e, also ent to re eed

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		15G300	B. W	ING		08/11	/2022
				CTDEET /	ADDRESS CITY STATE ZID COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD PIKE ST		
TRANCIT	TIONAL SERVICES	SUBLIC			NSVILLE, IN 46151		
IIVAINOII	TONAL OLIVIOES			IVIZALATI	140 VILLE, IIV 70 10 I		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		sting inedible items). The			A PD has been assigned to th		
	-	are staff documented an			home to provide oversight and		
		aggressing on staff leading to			monitoring of individuals, their		
	_	A in client A's record			plans and the home until a ne		
	_	rative notes and behavior			PD (QIDP) is trained (Hired to		
	tracking.				start 9.12.22). The acting PD		
	Finding include.				be retrained on recognizing ar		
	Findings include:				reporting ANE and following A		
	1) On 8/8/22 at 12:46 PM, a review of the facility's				policy. The new PD (QIDP) w	ill be	
					trained on recognizing and		
	incident/investigative reports was conducted and				reporting allegations of Abuse		
	indicated the following:				Neglect and Exploitation and I		
	O 5/12/22 (4.00 PM 5.1)				policies. The training will inc		
		PM, client A got upset with			how to investigate and a revie		
		22 Bureau of Developmental			the guidelines for timeliness n	oted	
		s (BDDS) incident report			in the Indiana Mentor policy.	_	
		/22, [client A] got upset with			The current PD will be retrained		
	_	e go on an outing. When he			and the new PD (QIDP) will be		
		sn't his afternoon to go on an			trained on the Supervisor Site		
	_	ating being scheduled on			review expectations. The		
	1	came verbally and physically			Supervisor Site Review form is		
		staff. He threw and hit staff			be turned into the Area Directo		
	_	ne and kicked a hole in the			(Regional Director in the abse	nce	
	_	en went after staff again			of an AD) monthly to ensure		
		reported he put his arms up to			oversight of the PD.		
		m hitting him and staff			The Program Director will retr		
	_	is arms and [client A] in the			the Program Supervisor and a	tii	
	I -	is arms and [client A] got hit in			other staff in the home	or	
		nd they bled. [Client A] also			documentation requirements f	OF	
		e phone at [client G] and hit Client A] was checked for			daily notes and also behavior	_	
	_	I up and an ice pack was put			tracking and unusual incidents This will be monitored as	> .	
		G] was checked for injuries as				ito	
		e and he said he was just sore.			described in the Supervisor Si visit form.	ii c	
		that staff hit him so staff was			VISIT IOIII.		
	suspended pending an investigation and to determine if corrective action or retraining needs						
		Staff will continue to follow					
	_	ehavior Support Plan). An					
		e completed to determine if any					
	i mvesugation will b	e completed to determine if any	1		i		I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G300	B. W	ING		08/11/	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R			PIKE ST		
TRANSIT	TIONAL SERVICES	SUBLIC			NSVILLE, IN 46151		
	·			100 (1 (1))	10101		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		eed to be completed and if					
		eds to be changed for his and					
	others' safety."						
	G. CC III	1 1 5/14/22 6 1:					
	_	nded on 5/14/22 after working					
		226 PM and 5/14/22 from 6:54					
		The facility failed to prevent					
	further potential abuse while an investigation was in progress.						
	in progress.						
	The 6/27/22 Incident Follow-Up Report indicated, "The internal investigation was completed and						
		egional Director on 6/17/2022.					
		ion it was determined the					
	_	ated. Staff was terminated					
	effective 6/17/22.	Staff has not worked in the					
	home during the inv						
	The 6/13/22 Interna	al Investigation indicated in					
	staff #1's statement	client A asked him to go on an					
		vening shift. Staff #1 told					
		his outing on 5/11/22 and					
	_	at A started hitting the back of					
		he van as well as hitting staff					
		vas driving. Staff#1's statement					
		indicated, "States he					
	_	ning he was told that in a					
	_	ral situation you vound (sic)					
		protect yourself States that					
	1	PD] said that if he couldn't find					
		switch places with [staff #7]					
		ack out on their van ride to get					
		States he asked [PD] about the					
		him coming in the next day and be him if he wanted to come in.					
		the next morning and was					
	1	a.m States [former Area					
		d him and asked how it was					
	1	told him (sic) was being					
		because [client A's] parents					
	suspended with pay	occause [elicht A s] parents					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	l í	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 08/11/	ETED
	PROVIDER OR SUPPLIER			110 W F	DDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	IATE	(X5) COMPLETION DATE
	informed them that uncomfortable with	[client A] said he was [staff #1]"					
	PD's statement, "s after the incident [client A] and that he #1] reported he had Intervention Alternate coming at him and his grips. States she him while using the intentional States suspended [staff #1] with [client A's] par [client A] to urgent States she does not nurse regarding his The 6/13/22 Internation staff #7's statement, anyone to come in fleave." The 6/13/22 Internation C's statement, #1] and [staff #1] him The 6/13/22 Internation C's statement, #1] and [staff #1] him The 6/13/22 Internation C's statement, #1] and [staff #1] him The 6/13/22 Internation C's statement, #1] and [staff #1] him The 6/13/22 Internation C's statement, #1] and [staff #1] him The 6/13/22 Internation C's statement, #1] and [staff #1] him The 6/13/22 Internation C's statement, #1] and [staff #1] him The 6/13/22 Internation C's statement, #1] and [staff #1] him The 6/13/22 Internation C's statement, #1] and [staff #1] him The 6/13/22 Internation C's statement, #1] and [staff #1] him The 6/13/22 Internation C's statement, #1] and [staff #1] him The 6/13/22 Internation C's statement, #1] and [staff #1] him The 6/13/22 Internation C's statement, #1] and [staff #1] him The 6/13/22 Internation C's statement, #1] and [staff #1] him The 6/13/22 Internation C's statement, #1] and [staff #1] him The 6/13/22 Internation C's statement, #1] and [staff #1] him The 6/13/22 Internation C's statement, #1] and [staff #1] him The 6/13/22 Internation C's statement, #1] and [staff #1] him The 6/13/22 Internation C's statement, #1] and [staff #1] him The 6/13/22 Internation C's statement, #1] and [staff #1] him The 6/13/22 Internation C's statement, #1] and [staff #1] him The 6/13/22 Internation C's statement, #1] and [staff #1] him The 6/13/22 Internation C's statement, #1] and [staff #1] him The 6/13/22 Internation C's statement, #1] and [staff #1] him The 6/13/22 Internation C's statement, #1] and [staff #1] him The 6/13/22 Internation C's statement, #1]	atives) and that [client A] was the had to hit him to get out of the understood that he had hit PIA. That it wasn't [former Area Director]] on Saturday after speaking the tents. States no one took care regarding his nose. know if he was seen by the					
	[staff #1]. States [staff #1]. S	I Investigation indicated in the section, "Evidence supports ing who was present at the the incident. Evidence was no Behavior Tracking ce supports there were no shift					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		15G300	B. WING		08/11/2022	
			CTREET	ADDRESS CITY STATE ZIR COD		
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD PIKE ST		
TDANGIT	FIONIAL OFFINIOFS	S SLIP LL C				
IRANSII	FIONAL SERVICES	S SUB LLC	IVIART	INSVILLE, IN 46151		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	grabbed [staff #1].	Evidence supports that [client				
	A] created a hazard	dous driving situation in the				
	group home van. I	Evidence supports that [staff				
		A], therefore the allegation of				
	physical abuse is s	-				
	The QIDP failed to	recognize an allegation of				
	-	ensure steps were taken to				
		were safe during the course of				
		The QIDP failed to ensure staff				
	_	cident in client A's behavior				
	tracking and shift r	notes. The QIDP failed to				
	ensure there was ac	dministrative oversight				
	implemented follow	wing the allegation of physical				
	abuse at the group	home. The QIDP failed to				
	ensure the van seat	ting arrangement was				
	addressed followin	g the incident.				
	On 8/8/22 at 3:26 I	PM, client A sent the surveyor a				
	picture of himself i	from 5/13/22. Client A's lower				
	and top lips were s	wollen on the left side. Both				
	his top and lower li	ips were purple, blue and red.				
	Client A had blood	l in the corners of his mouth.				
	Client A's nostrils	were bloody.				
		AM, a review of the 5/20/22				
		estigation Narrative section				
	indicated, in part, "	'I observed [client A] to have				
	bruised lips, both to	op and bottom and also (sic)				
	abrasion on his nos	se as well"				
		PM, a focused review of client				
		ducted. Client A's 12/6/21				
		Plan indicated he had a targeted				
		sion toward others (defined as				
	hitting and throwin	ng items at others). The plan				
	indicated, "The risl	k of (the) client's maladaptive				
	behavior is more h	armful than physical restraint				
	because of the risk	of physical harm to himself or				
	others, due to the s	everity of the client's past				
			1			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED	
		15G300	B. WI	NG		08/11/	/2022	
			_	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF P	ROVIDER OR SUPPLIER	R			PIKE ST			
TRANSIT	IONAL SERVICES	SUBITC			NSVILLE, IN 46151			
					101122, 111 10101			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE	
		The most minimal						
	_	ies will always be utilized first.						
		rvention methods included in						
		rt plan should always be						
		essary, and only after						
		reviously mentioned methods,						
	are the next restrictive interventions to be utilized. Other measures must be exhausted and an							
	imminent threat to the safety of self or others must be present to utilize Indiana Mentor Network							
	•							
	policy for physical management. Always begin							
	with the least restrictive intervention and proceed							
	per policy. Follow-up with the program director or program coordinator must be made with-in 15							
		the incident. Staff must contact						
		t within twenty-four hours.						
	-	1 if necessary and only if the						
		ninent threat to the health and						
		ers. The specific physical						
		for this individual includes the						
		interventions in the order listed						
	_	ventions are utilized): Escort						
		de, hand behind, and hand						
		v hand mid back), Releases and						
		eases, Manual One-Arm Hold,						
		o One Arm Hold, and Two Arm						
	Block to Wrap/One							
	•							
	On 8/8/22 at 1:27 P	M, the Quality Improvement						
	Specialist (QIS) ind	licated the lack of						
	documentation by t	he staff involved regarding the						
	incident should hav	e been addressed. On 8/9/22						
	at 12:25 PM, the Ql	IS indicated the van seating						
	arrangement was ac	ldressed in the investigation						
	however there was	nothing done to ensure the						
	van seating arrange	ment was changed. The QIS						
	indicated she was n	ot aware of increased						
	administrative over	sight at the group home						
	following the incide	ent.						

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	ì	UILDING	nstruction <u>00</u>	(X3) DATE COMPI 08/11/	ETED
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 110 W PIKE ST MARTINSVILLE, IN 46151				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE SICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	indicated initially the causing the injury to RD stated, "It was oneeded to be treated investigated and it vestigated and it vestigated and it vestigated and it vestigated for abuse abuse." The RD indicated the QIDP incident was documented to increased administry home following the compact of the RD indicated some following the compact of the results of the result	W227. For 2 of 3 clients in the the QIDP failed to ensure client dress pulling out his own hair plan to address PICA					
W 0227	483.440(c)(4) INDIVIDUAL PRO						
Bldg. 00	The individual pro	gram plan states the					

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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	(X3) DATE SURVEY COMPLETED 08/11/2022		
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC		110 W	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151		
(X4) ID PREFIX TAG	(EACH DEFICIENT REGULATORY O	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	(X5) COMPLETION DATE
	client's needs, as comprehensive a paragraph (c)(3) and Based on observation interview for 2 of 3 the facility failed to address pulling out a plan to address Prindings include: 1) On 8/8/22 from observation was conclient B had several was not a noticeable conducted in May 3. On 8/9/22 at 1:20 Hashavior Support I Client B's BSP indicated trichotillomania (a recurrent, irresistib The BSP indicated trichotillomania. Can Support Plan (ISP) trichotillomania. The prindicated client B is out however he was program. The PS is been witnessed at the indicated he had chead. The PS indicated the PS indicated he had chead.	ssessment required by	W 0227	The Nursing staff will reach of Client B's psychiatrist to determine what the appropriat course of treatment would be the possible reoccurrence of trichotillomania symptoms. Depending on the recommendations the Individual Support Plan and Behavior Support Plan will be updated staff trained on any changes. The Nursing staff will reach of Client C's psychiatrist for an appointment to be evaluated diagnosis of Pica. If Client C given the diagnosis of Pica hi Individual Support Plan will be updated and staff trained on changes. Responsible Parties: Region Director, Program Director, Nurse	te for ual and ut to for a is s

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/11/2022		
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP COD 110 W PIKE ST MARTINSVILLE, IN 46151				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTI			(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	DDEELY (EACH CORRECTIVE ACTION SHOULD		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	OBE COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	On 8/8/22 at 12:02	PM, the nurse indicated staff						
		2-3 weeks ago about client B's						
		urse stated, "staff think he's						
		f not witnessed it." The nurse						
		ssed it with his psychiatrist						
		ations were not changed. The						
		ent B went back to the						
		ek later for a movement exam						
		d for Tardive Dyskinesia (a the nervous system, often						
	_							
	caused by long-term use of some psychiatric drugs/causes repetitive, involuntary movements,							
	such as grimacing and eye blinking). The nurse							
	indicated client B denied pulling out his hair. The							
	nurse stated, "He says he's not doing it." The							
	nurse indicated she was not aware of a plan to							
	address this issue.							
	On 8/8/22 at 1:47 PM, the Behavior Clinician (BC)							
		ot aware client B was						
		lling. The BC stated "not been						
		cated there was no plan but						
		BC indicated she had been in						
		wever no one said anything						
	about client B's hair pulling.							
	2) On 8/8/22, client C was present at the facility operated day program. Client C used to work at an outside services workshop.							
	-							
	On 8/8/22 at 11:50 AM, the Program Supervisor (PS) for the facility-operated day program indicated client C started attending the facility-operated day program daily about one month ago. The PS indicated she was not sure why.							
	On 8/9/22 at 1.20 P	'M, a review of client C's						
	program plans was conducted. Client C's 2/10/22 Behavior Support Plan (BSP) did not include a							

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/11/2022		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 110 W PIKE ST MARTINSVILLE, IN 46151				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION		
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE DATE		
	targeted behavior o	f PICA. Client C's 1/25/21 port Plan did not address PICA.					
	ate and drank soap the outside services indicated an interdi outside services wo determined he was until there were par The nurse indicated addressing PICA. a plan.	PM, the nurse indicated client C out of the soap dispensers at workshop. The nurse sciplinary team meeting by the orkshop was conducted and not appropriate to be there rameters to ensure his safety. I client C did not have a plan The nurse indicated he needed PM, the Behavior Clinician (BC)					
	services workshop supervision than the client C was going soap. The BC indicated for PIC thought it was attent workshop indicated nothing was committee BC indicated h	to longer attended the outside due to requiring more bey can provide. She indicated into the bathroom to drink cated client C was supposed to CA. The BC indicated she atton seeking behavior. The left happened 3-4 times but funicated to the group home. The did not have a plan for PICA. The bed in the did not have a plan for PICA.					
W 0252	483.440(e)(1) PROGRAM DOC	UMENTATION					
Bldg. 00	criteria specified i plan objectives m measurable terms Based on record re- clients in the sampl ensure staff docume aggressing on staff	complishment of the n client individual program ust be documented in s. view and interview for 1 of 3 e (A), the facility failed to ented an incident of client A leading to staff abusing client rd including in his narrative	W 0252	The Program Director will ret the Program Supervisor and other staff in the home documentation requirements daily notes and also behavior	all for		

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 15G300		JILDING	00	COMPL 08/11/	ETED	
		130300	B. W1			00/11/	2022	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD 110 W PIKE ST				
TRANSII	TIONAL SERVICES	SUB LLC		MARTIN	NSVILLE, IN 46151			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE	
1710				mo	tracking and unusual incidents		DATE	
	notes and behavior tracking. Findings include:				This will be monitored as described in the Supervisor Sit visit form.			
	On 8/8/22 at 12:46	PM, a review of the facility's						
	incident/investigativ	ve reports was conducted and						
	indicated the follow	ring:						
	indicated the following: On 5/13/22 at 4:00 PM, client A got upset with staff #1. The 5/14/22 Bureau of Developmental Disabilities Services (BDDS) incident report indicated, "On 5/13/22, [client A] got upset with staff, demanding he go on an outing. When he was reminded it wasn't his afternoon to go on an outing due to his outing being scheduled on Wednesdays, he became verbally and physically aggressive toward staff. He threw and hit staff with the house phone and kicked a hole in the dining room. He then went after staff again physically and staff reported he put his arms up to block [client A] from hitting him and staff self-reported he accidentally hit [client A] in the face when raising his arms and [client A] got hit in (sic) lip and nose and they bled. [Client A] also threw another house phone at [client G] and hit				Responsible Parties: Program Director, Program Supervisor			
	him in the back. [Client A] was checked for injuries and cleaned up and an ice pack was put on his lip. [Client G] was checked for injuries as							
	well and found none and he said he was just sore. [Client A] reported that staff hit him so staff was suspended pending an investigation and to							
	to be completed S [client A's] BSP (Bo investigation will be corrective actions n	ive action or retraining needs Staff will continue to follow chavior Support Plan). An e completed to determine if any eed to be completed and if						
	[client A's] BSP needs to be changed for his and others' safety."							
	The Internal Investigation indicated in the Staff							

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	A. BU	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING 00 B. WING		COMPL	X3) DATE SURVEY COMPLETED 08/11/2022	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP COD 110 W PIKE ST MARTINSVILLE, IN 46151				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PROVIDER'S PLAN OF COR PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE	
		ility's electronic record keeping						
	,	t which shows that no case						
		incident were entered in						
		vior Tracking section of the						
		ted, "Discussion with the						
		shows that no behavior						
		eted for this incident."						
	On 8/8/22 at 3:58 P.	M, a focused review of client						
	A's record was cond	lucted. There was no						
	documentation rega	rding the incident in client A's						
	5/13/22 Note Summ	nary Report. There was no ABC						
	(antecedent/behavio	or/consequence) tracking for						
	5/13/22 to review.							
	On 8/8/22 at 1:47 P	M, the Behavior Clinician (BC)						
	indicated there was	no documentation regarding						
	the incident in clien	t A's behavior tracking						
		8/9/22 at 4:26 PM, the BC						
	stated, "It's a contin	uous struggle to get the staff						
	to document incider	nts."						
	On 8/8/22 at 1:27 P	M, the Quality Improvement						
	Specialist (QIS) indicated she did not address the lack of documentation by the staff involved regarding the incident. The QIS indicated it should have been addressed in the investigation.							
	The QIS indicated the staff should have							
	documented the inc	ident in client A's narrative						
	notes and on his AE	BC tracking form.						
	This federal tag rela	ites to complaint #IN00384168.						
	9-3-4(a)							

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