STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G300		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 03/13/2023	
	PROVIDER OR SUPPLIE		110 W	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151	
(X4) ID PREFIX TAG W 0000	(EACH DEFICIEN	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)	(X5) COMPLETION DATE
Bldg. 00	(PCR) to the PCR of investigation of coron 8/11/22.	Post Certification Revisit completed on 10/7/22 to the mplaint #IN00384168 completed	W 0000		
	This visit was in conjunction to the pre-determined full recertification and state licensure survey. This visit was in conjunction to the PCR to the investigation of complaint #IN00391340 completed on 10/7/22.				
	13, 2023. Facility Number: 0 Provider Number: AIM Number: 100 These deficiencies accordance with 46	15G300 249100 also reflect state findings in			
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BC The governing be policy, budget, ar the facility. Based on record re clients living in the and H), the facility	dy must exercise general doperating direction over view and interview for 8 of 8 group home (A, B, C, D, E, F, G s governing body failed to	W 0104	- The operation is in the process of hiring an Office Coordinator who is responsibl	
		direction over the facility by ere were policies and		employee files being current - Area Director and Prog	

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

TITLE

(X6) DATE 04/27/2023

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.

Bret Beauchamp

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Regional Director

		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	LETED	
		15G300	B. W	ING		03/13/	/2023	
				CTREET	ADDRESS SITY STATE ZID COD			
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD			
TDANOI	TIONAL OFFINIOFO	CLIPILLO			PIKE ST			
TRANSI	TIONAL SERVICES	SUB LLC		MARIII	NSVILLE, IN 46151			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	PROVIDER'S PLAN OF CORRECTION		
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 DEFICIENCY)	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	procedures in place	to ensure the group home			Directors will be trained on			
	staff's driver licenses remained valid.				ensuring employee files are u	p to		
					date when an Office Coordina	tor is		
	Findings include:				not present			
					- An audit of employee fi	les		
	On 2/28/23 at 3:00	PM, a review of staff files was			will be conducted to ensure th	at		
	conducted and indic	cated 2 staff had an expired			all items are current			
	driver's license in th	neir file. Staff #1's file had a			- Once an Office Coordi	nator		
	copy of a driver's li	cense that expired 6/11/2018			is hired, a tracking sheet will b	е		
		ad a copy of a driver's license			put into place to track all			
		2022. The facility did not			employees files to monitor any	y		
		a valid driver's license on file.			expirations that can be addres	sed		
	This affected clients A, B, C, D, E, F, G and H.				in a timely manner			
		AM, the Area Supervisor (AD)						
		he AD indicated staff driving			Persons Responsible: Area			
		hecked upon hire and then			Director, Program Director, Of	fice		
		they remain valid. The AD			Coordinator			
		responsibility of the staff for						
		th their licenses such as being						
		ed. The AD indicated the						
	1	duct motor vehicle checks after						
		AD indicated there has been						
		or to assist with employee						
	^ ^	stated, "we haven't had an						
		or over 6 months." The AD						
	-	lid driver's license "should be						
		and "there should be a policy						
	stating that".							
	Om 2/7/22 at 10:00	AM the Qualified Intellectual						
		AM, the Qualified Intellectual ional (QIDP)/Program Manager						
		staff should not be driving the						
		they do not have a current						
	~ .	e QIDP/PM stated proof of a						
		e "should be maintained in the						
	employees' file."	c should be maintained in the						
	employees me.							
	The Regional Direct	etor (RD) was interviewed on						
	_	I. The RD indicated the facility						
	1 2 25 25 11.00 7110	1 1 1 1 1 1	1		İ		I .	

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/13/2023
	ROVIDER OR SUPPLIER		110 W	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Vehicle checks. The	ng staff Bureau of Motor e RD stated employees "should s license in their employee file."			
	Supervised Group I was reviewed on 3/indicated, "Staff Sci Indiana MENTOR squalified applicants basis of their skills, and enthusiasm4. the transportation of license check and voobtained and documpersonnel file" Thindicating how the staffs' driver lice throughout their em. This deficiency was failed to implement to prevent recurrence.	Operating Practices Living Services dated 4/2011 13/23 at 9:00 AM and reening and Qualifications: strives to hire and retain for available positions on the knowledge, expertise, abilities For staff positions involving f individuals, a valid driver's cerification of insurance is mentation is maintained in each were was no policy/procedure facility was going to ensure censes remained valid ployment with the facility. The facility a systemic plan of correction ree. Lites to complaint #IN00384168.			
W 0420	9-3-1(a)				
W 0120 Bldg. 00	SOURCES	/IDED WITH OUTSIDE ssure that outside services			
	Based on record rev clients in the sample clients (G and H), the was a communication	riew and interview for 3 of 3 e (A, B and C) and 2 additional ne facility failed to ensure there on system in place between the facility-operated day	W 0120	- Home staff will be train on completing the communications and ensuring it is taken to Day Program daily - Day Program staff will trained on completing communication book	ation to

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G300	B. W	ING	_	03/13/	/2023
NAME OF T	NOTABLE OF CLUBS ASS		-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	:			PIKE ST		
TRANSIT	TIONAL SERVICES	SUB LLC		MARTII	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		LSC IDENTIFYING INFORMATION	+	TAG			DATE
	Findings include:				- Program Supervisor wi		
	Obsamuations was	and sated at the day was assess			monitor at least three times pe	er	
		conducted at the day program 00 AM through 11:00 AM. At			week during home visits	. ::11	
		t was made to review the			- Day Program Director v		
	_	ok from the group home. The			monitor daily at day program t ensure the communication bo		
		visor (DPS) was unable to			present and completed correc		
		me's communication book. The			- Program Director will	шу	
	~ .	mes they forget to bring it."			monitor at least once weekly		
		e group home should bring the			during Site Supervisory Visits		
		nportant communication tool."			during one oupervisory visits		
	, , , , , , , , , , , , , , , , , , , ,						
	On 2/28/23 at 6:30 PM staff #6 was interviewed.				Persons Responsible: Area		
	Staff #6 indicated a	communication book is used			Director, Program Director, Da	٩V	
	to communicate wit	h the facility-operated day			Program Director, Program	•	
	program. Staff #6 st	tated "the communication book			Supervisor		
	is a struggle" and "v	when we do remember to take					
	it to the day prograr	n, they are horrible at filling it					
	out." This affected of	clients A, B, C, G and H.					
	On 3/1/23 at 8:00 A	.M, the Program Director (PD)					
		home staff did not bring the					
	communication boo	ok on this date. The PD					
	indicated the staff w	vas supposed to use the					
	communication boo	k daily.					
	This deficiency was	s cited on 10/7/22. The facility					
		a systemic plan of correction					
	to prevent recurrence	•					
	0.2.1()						
	9-3-1(a)						
W 0149	483.420(d)(1)						
	STAFF TREATME	ENT OF CLIENTS					
Bldg. 00	The facility must d	levelop and implement					
	·	d procedures that prohibit					
		lect or abuse of the client.					
		and record review for 3 of 3	W ()149	- Program Director and A		04/28/2023
		ents A, B and C), plus 5			Director will be trained on incident		
	additional clients (c	lients D, E, F, G and H), the			reporting and investigations w	ith a	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u> </u>		
		15G300	B. WING		03/13/2023	
			STRE	ET ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	R		W PIKE ST		
TRANSI	TIONAL SERVICES	S SUB LLC		TINSVILLE, IN 46151		
	T					
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTI	ION (X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG		DATE	
	_	nplement its written policies and		specific outcome of investi	gations	
	•	oughly investigate an		within 5 business days	A	
		neglect and to thoroughly		- Program Director a		
	_	p and implement effective		Director will be trained on	ensuring	
		es regarding clients A and B's		recommendations from	- 4	
	elopements.			investigations are complet		
	Eindings in altrida			- Area Director will m		
	Findings include:			with Program Directors at		
	1 The facility's Du	reau of Developmental		weekly to discuss all incide and investigations	ants	
		es (BDDS) reports were		- All staff will be train	and on	
		23 at 12:30 PM. The review		incident reporting and notif		
	indicated the follow			management immediately		
	indicated the follow	wing.		incident	alter all	
	A BDDS report da	ted 11/17/22 at 12:56 AM		- All staff will be train	aed on	
	_	17/22, [client A] noticed the		Abuse and Neglect and Cl		
		P (Direct Support Professional)		Rights	iont ion	
	-	inside the home or on the		- Program Superviso	r will	
		called [staff #6] to report the		monitor and address any is		
		gram director) #1] was informed		during home visits at least		
		11/17/22 at 12:02pm. Plan to		times per week		
		was immediately suspended		- Program Director w	vill	
		ne of this investigation. This		monitor and address any is		
	-	nitiated on 11/17/22, and it will		the home at least once we		
	_	timely manner." This affected		during Site Supervisory vis	-	
	clients A, B, C, D,	E, F, G and H.		- Area Director will m		
				at least once weekly during		
	A BDDS Incident	Follow Up dated 11/18/22		Supervisory Visits	-	
] interviewed [Staff #9] on				
	11/17/2022. [Staff	#9] stated she did not leave the				
	home during her sl	nift. [Staff #9] stated she went		Persons Responsible: Are	a	
		around 11pm) to smoke, but it		Director, Program Director		
	was too cold, and she quickly returned inside the			Program Supervisor, Regi	onal	
		ated the only resident she saw		Director		
		[client B] when she made him				
		en 1-2 am. [Staff #9] stated she				
	did not see another	resident during her shift.				
	_	[‡] 1] spoke with [staff #6]. [Staff				
I	#6] stated [client A	Al called him around 1 AM on	Ī			

<u> </u>		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED			
		15G300	B. WING		03/13/2023	
NAME OF P	DOMDED OF CURPUSE		STREET	ADDRESS, CITY, STATE, ZIP COD	•	
	PROVIDER OR SUPPLIER			PIKE ST		
TRANSIT	TIONAL SERVICES	SUB LLC	MARTI	NSVILLE, IN 46151		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	COMPLETED 03/13/2023 (X5) COMPLETION	
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	NIE .	
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		stated [client A] told him [staff				
	-	nd returned 20 to 30 minutes ed [client A] reported [Staff #9]				
		na. [Client #6] reportedly told				
	[client A] he would					
	1					
	On 11/18/22, [PD #	1] interviewed [client A] via				
		A] stated he saw [staff #9]				
		pproximately midnight. [Client				
	_	ed about 30 minutes later.				
		he was looking out his window				
		and went across the street. e door alarm did go off when				
		stated [client B] was also				
		[Client A] stated this happened				
		ng time ago.' [Client A] did not				
		melling of marijuana.				
	O 11/10/02 FPD //	11.1. (D)				
	_	1] interviewed [client B] via				
		B] stated he was looking out his w [Staff #9] leave. [Client B]				
		the street, but he did not				
		ent from there. [Client B] stated				
		e door alarms went off when				
		vas not sure how long she was				
	-	eturned. [Client B] had no				
	_	ehavior happening prior to				
	11/17/22.					
	Describe systemic a	actions being taken to assume				
	-	sues: There is a lack of				
		the allegation that [staff #9]				
	• •	g her shift. On 11/17/22, [PD				
	#1] discussed with	[staff #9] that leaving the				
		shift was absolutely				
		ould result in disciplinary				
		ated she understood, and she				
	did not leave the pro					
		ence, [Staff #9] should be				
	allowed to return to	WOFK."				

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			O	MB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATI	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMP	PLETED
		15G300	B. WING		03/13	3/2023
NAME OF I	PROVIDER OR SUPPLIEF	3		ADDRESS, CITY, STATE, ZIP COD		
01 1	no (ibbit off boll bib)		110 W	PIKE ST		
TRANSI	ΓΙΟΝΑL SERVICES	SUB LLC	MARTII	NSVILLE, IN 46151		
(X4) ID	SUMMARV	STATEMENT OF DEFICIENCIE	ID	I		(Y5)
				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPRO		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
		eports indicated the facility				
	failed to thoroughly	investigate the allegation				
	made by client A. T	The facility failed to address the				
	allegation that staff	#9 smelled like marijuana.				
	The Area Director ((AD) was interviewed on 3/7/23				
		AD indicated the investigation				
		previous program director.				
	_	he allegation was not				
		9				
		ated. The AD stated "the				
		licy should have been				
		g the allegation the staff				
	smelled like mariju	ana.				
	-	lectual Disabilities Professional				
	(QIDP)/Program D	irector (PD) was interviewed on				
	3/7/23 at 10:00 AM	I. The QIDP/PD indicated he is				
	trained on investiga	ations. The QIDP/PD indicated				
	_	as not thorough. The QIDP/PD				
	_	n of drug use by a client would				
	warrant drug testing					
	warrant drug testing	g for the starr.				
	2 The facility's Du	reau of Developmental				
		es (BDDS) reports were				
		· · · · · ·				
		3 at 12:30 PM. The review				
	indicated the follow	ving:				
	A DDDG (1)	-112/22/22 -4 8-20				
	•	ed 12/22/22 at 8:30 am				
		2/2022 about 6:30 AM [client				
		ng that staff take him to the				
	bank to cash his \$22	2 check that had arrived in the				
	mail earlier in the w	veek. Staff informed [client A]				
	that the bank didn't	open until about 8:30 AM and				
	that they would take	e him to the bank between 8:30				
	_	at 8:30 AM [client A] started				
		ff take him to the bank. Staff				
	_	d take him as soon as they				
	_	ey were working on. [Client A]				
	I mished the task the	ey were working on. [Chent A]		1		1

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began screaming at staff and said f--- you, I need

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/13/2023
	PROVIDER OR SUPPLIEF		110 W I	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL 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
IAU	my chew, I'm going self. [Client A] ther immediately grabbe began following [cl [client A] staff repethe van due to the context they would drive his refused to get in the the direction of the A] walked up to the cashed his check. A A] still refused to ginstead walked to the chewing tobacco. A station [client A] agwith staff and walke arrived back at the low walking [client A] as safety skills. [Client staff the entire time house. The bank that from his home and is roughly 9 blocks. There were no furth of the day. Staff will BSP (Behavior Supto use his coping skills away without the bank [client A] housemate [client B] blocks away without the bank [client A] housemate [client B] addresses untrustwo Plan to Resolve: Staff of the van the solve: Staff will place the same count [client A] has a BS addresses untrustwo Plan to Resolve: Staff will place the same count [client A] has a BS addresses untrustwo Plan to Resolve: Staff will place the same count [client A] has a BS addresses untrustwo Plan to Resolve: Staff will place the same count [client A] has a BS addresses untrustwo Plan to Resolve: Staff will place the same count [client A] has a BS addresses untrustwo Plan to Resolve: Staff will place the same count [client A] has a BS addresses untrustwo Plan to Resolve: Staff will place the same count [client A] has a BS addresses untrustwo Plan to Resolve: Staff will place the same count [client A] has a BS addresses untrustwo Plan to Resolve: Staff will place the same count [client A] has a BS addresses untrustwo Plan to Resolve: Staff will place the same count [client A] has a BS addresses untrustwo Plan to Resolve: Staff will place the same count [client A] has a BS addresses untrustwo Plan to Resolve: Staff will place the same count [client A] has a BS addresses untrustwo Plan to Resolve: Staff will place the same count [client A] has a BS addresses untrustwo Plan to Resolve: Staff will place the same count [client A] has a BS addresses untrustwo Plan to Resolve: Staff will place the same count [client A] has a	without you then by my d n exited the house. Staff ad the keys to the van and ient A]. While following atedly prompted him to get in old temperature and said that in to the bank. [Client A] is van and continued walking in bank. Once at the bank [client is drive thru window and offer cashing his check [client iget in the van with staff and in gas station to buy himself offer walking out of the gas igain refused to get in the van ight and the way home. [Client A] incuse roughly 9:37 AM. While ight and was within line of sight of that he was away from the int [client A] uses is 2 blocks the gas station that he went to from away from his home. It is a station to follow [client A's] ignort Plan) and encourage him it is a support Plan and encourage him it when he is upset." The de 2/10/23 at 12:30 PM 0/2023 [client A] left the group of and walked to the bank 2 to the staff supervision. While at	IAU		DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G300		(X2) MULTIPLE CC A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 03/13/2023	
	PROVIDER OR SUPPLIER		110 W I	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	A] was interviewed that he eloped from afternoon on 2/10/2 took [client B's] ide bank and attempted stated that he did not o cash it. [Client A and [staff #5] were stated that he told sto vape and went to that [staff #5] was in the living room. Is less than two blocestimated that he was [Staff #5] was interstated that she was Group Home on 2/1 heard the door alarmstated that she open A] vaping on the fronthat she went back to [Staff #5] stated that cleaning and assisting room. [Staff #5] stated that cleaning and assisting attempting to cash a identification. When she stated that [client A] denies stated that [client A] denies tated that he was in that [client A] was interstated that he was in A] went out the door	ted 2/22/23 indicated, "[Client on 2/21/23. [Client A] stated the house during the 3. [Client A] stated that he ntification card and went to the to withdraw money. [Client A] of take his check and attempt at take his check and attempt that he was going outside the bank. [Client A] stated in the office and [staff #4] was [Client A] stated that the bank cks from the home. [Client A] as gone for only ten minutes. Wiewed on 2/21/23. [Staff #5] working in the Martinsville 0/23. [Staff #5] stated that she in by the front door. [Staff #5] ed the door and saw [client ont porch. [Staff #5] stated to the office to complete work. It other staff [staff #4] was ing other clients in the living ted that she received a phone claiming that [client A] was in check and had [client B's] in [staff #5] got off the phone, and A] had walked in the door the kitchen. [Staff #5] stated ad leaving the home. [Staff #5] denied having [client B's] wiewed on 2/21/23. [Staff #4] in the living room when [client bits.] It is the living room when [client bits.]			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G300		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 03/13/2023
	PROVIDER OR SUPPLIER TONAL SERVICES SUB LLC	110 W F	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
IAU	[Staff #4] stated that he continued cleaning the home. [Staff #4] stated that he saw [client A] walk into the home after approximately ten minutes. [Staff #4] stated that [staff #5] informed him that the bank called and stated [client A] was there. [Staff #4] stated that [client A] denied having [client B's] identification card. [Staff #6] was interviewed on 2/22/23. [Staff #6] stated that [staff #5] notified him of [client A's] elopement. [Staff #6] stated that he spoke with a representative from the bank and they stated that [client A] attempted to cash [client B's] check with [client B's] identification card. [Staff #6] stated that [client A] denied having [client B's] identification at first but admitted to using it to attempt to withdraw money. [Staff #6] stated that [client A] returned the identification card but did not return the check. [Staff #6] stated that [client A] gets the mail at times and believes he took the check then. [Staff #6] stated that he is attempting to call Social Security to cancel the check and get a new one issued for [client B]. [Client B] was interviewed on 2/21/23. [Client B] stated that he was not aware of [client A] taking his identification card until it was returned. [Client B] stated that he will keep it in his wallet for safe keeping. [Client B] stated that he was not angry with [client A] and enjoys living in the home with him. Conclusion: It is substantiated that [client A] took [client B's] identification and Social Security check and attempted to cash it at the bank, it is also	TAG		DATE
	substantiated that [client A] eloped from the home for approximately ten minutes. Recommendations: All staff retrained on [client A's] BSP for elopement and stealing. Staff will join			

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00 COMPLETED B. WING 03/13/2023			
		15G300	B. WI	ING		03/13/	/2023
NAME OF F	PROVIDER OR SUPPLIER		-		ADDRESS, CITY, STATE, ZIP COD		
					PIKE ST		
IKANSII	FIONAL SERVICES	20R FFC		MARIIN	NSVILLE, IN 46151		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
TAG		LSC IDENTIFYING INFORMATION when he vapes. Team will meet		TAG			DATE
		at securing his identification					
		curing if requested. Team will					
		al Security check for [client B]					
	and will reimburse	if he is not able to obtain it.					
	Staff will observe in	ndividuals getting the mail to					
	I -	als checks are received.					
	Completed by: [Reg	gional Director] 2/22/23"					
	The review of recor	ds indicated the facility did not					
		t due to staff not being aware					
	that client A eloped	from the home. The review					
	indicated recommendations made by the						
	investigator were no	ot implemented.					
	The Area Director ((AD) was interviewed on 3/7/23					
		AD indicated the investigation					
		previous program director.					
	1	he allegation was not					
	thoroughly investig	ated. The AD stated					
	"investigations shou	ald first look into whether or					
	_	ectful in caring for the clients."					
		ecommendations should be					
		emented. The AD stated the					
		rom client A's elopements were					
		et because "we were going to					
	do that this week."						
	The Qualified Intell	lectual Disabilities Professional					
	(QIDP)/Program Di	irector (PD) was interviewed on					
		. The QIDP/PD indicated he is					
	_	ed. The QIDP/PD indicated the					
	_	ot thorough. The QIDP/PD					
		ations should be addressed as					
	_	the action doesn't occur					
	again."						
	3. The facility's Bur	reau of Developmental					
	1	s (BDDS) reports were					
		3 at 12:30 PM. The review					

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	PROVIDER OR SUPPLIEF			110 W F	NDDRESS, 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)	ΓE	(X5) COMPLETION DATE
TAG	indicated the follow A BDDS report dat indicated, "On 02/0 eating his lunch he he was still hungry. and [client B] began and peers. [Client B over the ash tray on multiple times that home. Staff informs property that they we the staff were the or moment. About 12: property walking in station that he enjoy that time staff called local police departm [client B] at the near with [client B] at the near with [client B] and and then drove him incidents for the remain and alone time of where local law enforced light passed by the staff will be a change to his minute alone time of where local law enforced light passed by the staff will BSP." A BDDS report dat indicated, "On 02/1 woke up from a nagunknown reasons. A went upstairs to [client b] client by the staff will be staff with the staff called the staff will be staff w			TAG			DATE
		taff on shift at the time. Police					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION OO	COMP	LETED 3/2023
	PROVIDER OR SUPPLIEF		110 \	ET ADDRESS, CITY, STATE, ZIP COD W PIKE ST RTINSVILLE, IN 46151	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED FICIENCY)	TION LD BE ROPRIATE	(X5) COMPLETION DATE
	[Client B] has a BS towards others, desidisruptive behavior uncooperative behavior on 02/20/2023 to reand is currently awainvestigation is being money."	to the house about 8:50 pm. P that addresses aggression fructive to property, It socially offensive behavior, It wior, elopement, and It or. Plan to Resolve: Staff met It wise BSP to allow alone time It with a staff met It wise BSP to allow alone time I				
	indicated, "On 2/20 became agitated for house. Staff following as station near the way into the station attendant out of the came to the station [client B] was calm and was transported that addresses aggreed destructive (sic) to provide the station of the station and was transported that addresses aggreed destructive (sic) to provide the station of	vunknown reasons and left the ed [client B] in a vehicle to a house. [Client B] forced his pushing the gas station way. Police were called and to speak with [client B]. Once he got in staffs (sic) vehicle I home. [Client B] has a BSP ession towards others, property, disruptive behavior, ehavior, uncooperative t, and hyperactive behavior. Iff will continue to follow [client etions between individuals for				
	B] was interviewed that he became upso money for a drink a stated that he walke [staff #10] attempte Group Home. [Clie him at the gas statio #10] asked him to n return home with he	ted 2/27/23 indicated, "[Client on 2/21/23. [Client B] stated et because [client A] received nd he wanted one. [Client B] d to the gas station and staff d to have him come back to the nt B] stated that [Staff #10] met on. [Client B] stated that [staff tot enter the gas station and er. [Client B] stated that the gas d him not to enter and to listen				

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		ROVIDER OR SUPPLIER		110 W F	NDDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151		
P	(4) ID REFIX 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)	ΤE	(X5) COMPLETION DATE
		to his staff. [Client and went in the gas he did not push the threats towards then a drink while in the [Client B] stated that staff and began wal [Client B] stated that spoke to him about without permission returned back to the with the police. [Staff #5] was interstated that she was with the other indivibuted that she notice stated that she notice stated that she did in himself into the gas when [Client B] left ride home. [Staff #5] [client B] speaking to him about not lead permission. [Staff #6] end of the permission. [Staff #6] from DSP [staff #1] group home and [steonvince [client B] #6] stated that [staff was refusing to return the gas station after stated and spoke to walking home. [Staff #6] Staff	B] stated that he ignored them station. [Client B] stated that gas station staff nor make any m. [Client B] stated that he got gas station and paid for it. at he refused to ride home with king back to the group home. at the police stopped him and not leaving the group home. [Client B] stated that he group home after speaking viewed on 2/22/23. [Staff #5] driving the van on an outing riduals in the home. [Staff #5] sed staff [staff #10] at the gas I [Client B] go inside. [Staff #5] not witness [Client B] force a station. [Staff #5] stated that it the gas station, he refused a solution is stated that she witnessed with the police and they spoke aving the group home without the group home without stated that he received a report 1] that [client B] eloped from the aff #10] was attempting to to return to the home. [Staff #6] prorted that [client B] arm to the home and went into the being told not to. [Staff #6] prorted that the police were [client B] while he was ff #6] stated that no further reted to him that night				

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	PROVIDER OR SUPPLIER		110 W I	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL 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
	[Staff #11] DSP, wa #11] stated that he was then night of 2/20/23 witnessed [client B] #10], DSP, followed stayed at the home present. [Staff #11] incident to [Staff #6 #11] stated that staff defiant and entered permission. [Staff # that [client B] refuse were called. [Staff # not have any further [Staff #10], DSP, we [Staff #10] stated the eloped from the hor stated that she atten back to the home. [Staff #10] stated the asked [staff #10] if [Staff #10] stated the staff that she will at he was there without stated when [client told him not to ente [Staff #10] stated the entered the gas stati #10] stated that the call the police in which stated that [client B] contact with the gas staff but it was unin that [client B] refuse [Staff #10] stated the gas staff but it was unin that [client B] refuse [Staff #10] stated the gas staff #10] stated the gas staff #10] stated the gas staff #10] stated that [client B] refuse [Staff #10] stated the gas staff #10] stated the gas staff #10] stated the gas staff #10] stated that [client B] refuse [Staff #10] stated the gas staff #10] stated #10] sta	as interviewed on 2/27/23. [Staff was working in the home on . [Staff #11] stated that he leave the home and [Staff d him. [Staff #11] stated that he with remaining individuals stated that he reported the by, Program Supervisor. [Staff f told him that [Client B] was the gas station without 11] stated that staff told him ed a ride home and the police with the stated that [Client B] did to incidents that evening. as interviewed on 2/27/23. [Staff #10] and to get [client B] to come staff #10] stated that when she met him at the gas station. The gas station attendant [client B] was on his way. The gas station staff to get [client B] home as at permission. [Staff #10] B] arrived the gas station staff and to go home with staff. The gas station staff gas station staff asked her to nich she did so. [Staff #10] may have made slight			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	(X2) MULTIPLE C A. BUILDING B. WING	OONSTRUCTION 00	(X3) DATE S COMPLE 03/13/2	ETED
	PROVIDER OR SUPPLIER		110 W	ADDRESS, CITY, STATE, ZIP COD PIKE ST INSVILLE, IN 46151	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E RIATE	(X5) COMPLETION DATE
	home, police office him about not leavi	at while [client B] was walking rs stopped him and spoke with ng the home without [10] stated that [Client B] out further incident.				
		bstantiated that [client B] ne, it is unsubstantiated that e gas station staff.				
	updated BSP that in [client B], staff will	Staff will be trained on acludes alone time each day for be trained on incident ion. Competed by [Regional				
	for the 2/5/23 and 2 and theft of client A indicated the invest followed client B's	d there was no investigation /19/23 incidents of elopement c's money. The review igation did not address if staff BSP to address his behavior of up to the elopement.				
	at 10:00 AM. The A investigation for cli and 2/19/23. The A (investigation) for t stated the investigat	AD) was interviewed on 3/7/23 AD indicated there was no ent B's elopements on 2/5/23 D stated, "I don't have one hose incidents." The AD cion was conducted "by the or [client B's] last elopement."				
	The AD indicated the thoroughly investig "incidents of eloper or not the client's B	the allegation was not ated. The AD stated ment should address whether SP was followed by staff."				
	(QIDP)/Program Di 3/7/23 at 10:00 AM investigation should	irector (PD) was interviewed on The QIDP/PD indicated the have addressed whether or o follow client B's BSP. The				

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	PROVIDER OR SUPPLIER		110 W	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
		ere were some items left out of			2.112
	Risk Management previewed. The policy Mentor promotes a seeks to protect ind Mentor services thre management procedules monitoring of process of identifying risk to which indivity 2011 Human Rights following actions at Indiana MENTOR: mistreatment of an an individual's fundindividual's rights." This deficiency was failed to implement to prevent recurrence.	dures and company operations, service delivery and through a ang evaluating and reducing duals are exposed" The April is policy indicated, in part, "The re prohibited by employees of abuse, neglect, exploitation or individual including misuse of as; or violation of an			
W 0154 Bldg. 00	I -	nave evidence that all			
	Based on record rev allegations of abuse unknown origin rev F, G and H, the faci allegation of staff n investigated, and fa	are thoroughly investigated. View and interview for 6 of 6 c, neglect and injuries of riewed for clients A, B, C, D, E, allity failed to ensure an eglect was thoroughly illed to thoroughly investigate and for clients A and B.	W 0154	Program Director and A Director will be trained on incireporting and investigations we specific outcome of investigat Area Director and Programment Director will be trained on ensure recommendations from investigations are completed.	dent iith a ions gram

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		15G300	B. W	ING		03/13/	/2023
				STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			PIKE ST		
TRANSIT	TIONAL SERVICES	SUBLIC			NSVILLE, IN 46151		
III				IVIZITI			
(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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Findings include:				- Area Director will meet		
					with Program Directors at leas		
	1	u of Developmental Disabilities			weekly to discuss all incidents	i	
		reports were reviewed on			and investigations		
		M. The review indicated the			- All staff will be trained	on	
	following:				incident reporting		
	1. A BDDS report dated 11/17/22 at 12:56 AM indicated, "On 11/17/22, [client A] noticed the				- Program Supervisor wi		
					monitor and address any issue		
					during home visits at least three	ee	
	_	P (Direct Support Professional)			times per week		
		nside the home or on the			- Program Director will		
	property, [client A] called [staff #6] to report the				monitor and address any issue		
		ram director) #1] was informed			the home at least once weekly	/	
		1/17/22 at 12:02pm. Plan to was immediately suspended			during Site Supervisory visits	.	
		ne of this investigation. This			- Area Director will moni		
		nitiated on 11/17/22, and it will			at least once weekly during Si Supervisory Visits	ıe	
	1 -	imely manner." This affected			Supervisory visits		
	clients A, B, C, D,						
	chemis A, B, C, B,	L, 1 , G and 11.			Persons Responsible: Area		
	A BDDS Incident I	Follow Up dated 11/18/22			Director, Program Director,		
		interviewed [Staff #9] on			Program Supervisor, Regiona	I	
		#9] stated she did not leave the			Director	•	
	_	ift. [Staff #9] stated she went			Biroctor		
	_	round 11pm) to smoke, but it					
	· ·	he quickly returned inside the					
		ated the only resident she saw					
		[client B] when she made him					
	_	n 1-2 am. [Staff #9] stated she					
		resident during her shift.					
	On 11/18/22 [PD #	1] spoke with [staff #6]. [Staff					
	#6] stated [client A] called him around 1 AM on					
	11/17/22. [Staff #6]	stated [client A] told him [staff					
	#9] left the home as	nd returned 20 to 30 minutes					
	later. [Staff #6] stated [client A] reported [Staff #9] smelled of marijuana. [Client #6] reportedly told						
	[client A] he would	handle it.					
	On 11/18/22, [PD #	†1] interviewed [client A] via					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G300		(X2) MULTIPLE CO A. BUILDING B. WING	COMPLETEI	(3) DATE SURVEY COMPLETED 03/13/2023		
	PROVIDER OR SUPPLIER		110 W F	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	O BE CO	(X5) MPLETION DATE
	leave the home at any A] stated she return [Client A] reported when [staff #9] left [Client A] stated the she left. [Client A] awake at that time. one other time 'a lon mention [staff #9] s On 11/18/22, [PD # telephone. [Client E window when he sa stated he saw her in know where she we he is 'pretty sure' the she left, [client B] v gone or when she re knowledge of this b 11/17/22. Describe systemic a health and safety Is: evidence to support left the home during #1] discussed with property during her inappropriate and coaction. [Staff #9] stadid not leave the product of lack of evide allowed to return to The review of the refailed to thoroughly made by client A. Tallegation that staff	ence, [Staff #9] should be				

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	
		15G300	B. W	ING		03/13/	/2023
N. M. C. C. C.	DROLUBER OF CLUBS			STREET A	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF P	PROVIDER OR SUPPLIER	Š.			PIKE ST		
TRANSIT	TIONAL SERVICES	SUB LLC		MARTIN	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	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		AD stated the investigation was					
		vious program director. The					
		legation was not thoroughly					
	_	D stated "the suspicion of use					
		been followed" regarding the					
	allegation the staff smelled like marijuana.						
	The Qualified Intell	lectual Disabilities Professional					
		irector (PD) was interviewed on					
		. The QIDP/PD indicated he is					
	trained on investiga	tions. The QIDP/PD indicated					
	the investigation wa	as not thorough. The QIDP/PD					
	stated "an allegation	n of drug use by a client would					
	warrant drug testing for the staff."						
	2. A BDDS report d	lated 12/22/22 at 8:30 am					
	indicated, "On 12/2	2/2022 about 6:30 AM [client					
	A] started demanding	ng that staff take him to the					
	bank to cash his \$22	2 check that had arrived in the					
	mail earlier in the w	veek. Staff informed [client A]					
	that the bank didn't	open until about 8:30 AM and					
	that they would take	e him to the bank between 8:30					
	and 9:00 AM. Abou	it 8:30 AM [client A] started					
	demanding that staf	f take him to the bank. Staff					
	said that they would	l take him as soon as they					
		ey were working on. [Client A]					
		staff and said f you, I need					
	'	without you then by my d					
		exited the house. Staff					
		ed the keys to the van and					
		ient A] . While following					
		atedly prompted him to get in					
		old temperature and said that					
	1 -	m to the bank. [Client A]					
	I -	e van and continued walking in					
		bank. Once at the bank [client					
		drive thru window and					
		fter cashing his check [client					
	A] still refused to g	get in the van with staff and					
	instead walked to th	ne gas station to buy himself					

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	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 ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
	station [client A] as with staff and walk arrived back at the walking [client A] as afety skills. [Clien staff the entire time house. The bank the from his home and is roughly 9 blocks There were no furth of the day. Staff wi BSP (Behavior Sup to use his coping skills. [Client A] house about 12:30 plocks away without the bank [client A] housemate [client B [client A] has a BS addresses untrustwe Plan to Resolve: Staff [client A's] BSP and initiated." An investigation date A] was interviewed that he eloped from afternoon on 2/10/2 took [client B's] ide bank and attempted stated that he did not o cash it. [Client A and [staff #5] were stated that he told staff #5] were stated that he told staff #5]	after walking out of the gas gain refused to get in the van ed all the way home. [Client A] house roughly 9:37 AM. While exhibited good pedestrian that A] was within line of sight of that he was away from the at [client A] uses is 2 blocks the gas station that he went to from away from his home. Her incidents for the remainder all continue to follow [client A's] apport Plan) and encourage him cills when he is upset." Idated 2/10/23 at 12:30 PM 0/2023 [client A] left the group form and walked to the bank 2 at staff supervision. While at attempted to access att					

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G300		 JILDING	nstruction <u>00</u>	(X3) DATE COMPL 03/13/	ETED	
	PROVIDER OR SUPPLIEF		110 W F	ODDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	that [staff #5] was i in the living room. is less than two blood estimated that he was stated that she was a Group Home on 2/1 heard the door alarmstated that she open A] vaping on the frought that she went back to [Staff #5] stated that cleaning and assisting room. [Staff #5] state call from the bank of attempting to cash a identification. When the stated that [client A] denies stated that have sin A] went out the door #5] checked on him [Staff #4] stated that home. [Staff #4] stated that home after [Staff #4] stated that [client B's] identification [Staff #4] stated that [client B's] identification [Staff #4] stated that [staff #5] elopement. [Staff #5] elopement. [Staff #5]	n the office and [staff #4] was [Client A] stated that the bank cks from the home. [Client A] as gone for only ten minutes. viewed on 2/21/23. [Staff #5] working in the Martinsville 10/23. [Staff #5] stated that she in by the front door. [Staff #5] ed the door and saw [client bont porch. [Staff #5] stated to the office to complete work. It other staff [staff #4] was ing other clients in the living ted that she received a phone claiming that [client A] was in check and had [client B's] in [staff #5] got off the phone, but A] had walked in the door in the kitchen. [Staff #5] stated and leaving the home. [Staff #5] and went back into the office. It he continued cleaning the living room when [client bont of the kitchen that stated that he saw [client A] walk approximately ten minutes. It [staff #5] informed him that stated [client A] was there. It [client A] denied having	TAG	DEPALENC! 1		DATE

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		(X2) MUL	ΓIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	DING	00	COMPL	ETED
		15G300	B. WINC	·		03/13/	2023
			5	STREET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			PIKE ST		
TRANSI	TIONAL SERVICES	S SUB LLC	ľ	MARTIN	NSVILLE, IN 46151		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	1	ΓAG	DEFICIENCY)		DATE
		ed to cash [client B's] check with					
		cation card. [Staff #6] stated					
		ied having [client B's] st but admitted to using it to					
		w money. [Staff #6] stated that					
	_	If the identification card but did					
		k. [Staff #6] stated that [client					
		times and believes he took the					
		#6] stated that he is attempting					
	_	rity to cancel the check and get					
	a new one issued for	or [client B].					
		erviewed on 2/21/23. [Client B]					
		not aware of [client A] taking					
		ard until it was returned. [Client					
	_	ill keep it in his wallet for safe] stated that he was not angry					
		l enjoys living in the home with					
	him.	enjoys name in the nome with					
	Conclusion: It is su	abstantiated that [client A] took					
	[client B's] identifi	cation and Social Security check					
	_	ash it at the bank, it is also					
	_ ·	[client A] eloped from the home					
	for approximately	ten minutes.					
	Recommendations	: All staff retrained on [client					
		ment and stealing. Staff will join					
		when he vapes. Team will meet					
	with [client B] abo	out securing his identification					
		ecuring if requested. Team will					
	-	al Security check for [client B]					
		if he is not able to obtain it.					
		individuals getting the mail to					
	1	uals checks are received. egional Director] 2/22/23"					
	Completed by: [Re	egional Difectory 2/22/25					
	The review of reco	ords indicated the facility did not					
		ct due to staff not being aware					
	that client A elope	d from the home. The review					
I	1		ı	l			

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	EMENT OF DEFICIENCIES PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	TE SURVEY PLETED 3/2023
	E OF PROVIDER OR SUPPLIE NSITIONAL SERVICES		110 W I	ADDRESS, CITY, STATE, ZIP COI PIKE ST NSVILLE, IN 46151)	
(X4) I PREF	X (EACH DEFICIEN	STATEMENT OF DEFICIENCIE SICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION ULD BE PROPRIATE	(X5) COMPLETION DATE
		ndations made by the				J.M.B
	at 10:00 AM. The acconducted by a predicted by a predicted by a predicted and investigated. The Act should first look in neglectful in caring indicated recommendations for the implemented and implemented and implemented and implemented and implemented and implemented and that this week." The Qualified Intel (QIDP)/Program Digital 3/7/23 at 10:00 AM investigations train investigation was mostated "recommend soon as possible so again."	(AD) was interviewed on 3/7/23 AD stated the investigation was vious program director. The llegation was not thoroughly AD stated "investigations to whether or not staff were a for the clients." The AD indations should be developed The AD stated the arom client A's elopements were get because "we were going to because "we were going to be lectual Disabilities Professional irector (PD) was interviewed on a function of the QIDP/PD indicated he is good thorough. The QIDP/PD actions should be addressed as the action doesn't occur dated 2/5/23 at 12:35 PM 05/2023 after [client B] finished				
	eating his lunch he he was still hungry and [client B] bega and peers. [Client I	became upset and stated that . Staff offered him more food n yelling and cussing at staff B] also slammed doors, knocked				
	multiple times that home. Staff inform property that they were the staff were the omoment. About 12 property walking it station that he enjo	the porch and informed staff he was going to leave the ed [client B] that if he left the would have to call the police as nly staff at the house at the ed:35 PM [client B] left the in the direction of a nearby gas ys going to to get drinks. At d management and then call the				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G300		A. BUILDING B. WING	00 00	COME	E SURVEY LETED 3/2023	
	PROVIDER OR SUPPLIER		110 W I	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
	[client B] at the neal with [client B] and I and then drove him incidents for the ren had a change to his minute alone time d where local law enficient B] leaves the B] has good pedestrisk when walking i Resolve: Staff will describe BSP." 5. A BDDS report doindicated, "On 02/19 woke up from a napunknown reasons. A went upstairs to [client worth of change and and left the house. Seassistance to locate to there being one streturned [client B] towards others, dest disruptive behavior, uncooperative behavior	nent for assistance. Police met rby gas station. Police spoke bought him a fountain drink home. There were no further nainder of the day. [Client B] BSP that removed his 30 use to misuse and put in place by the process of the process of the day. [Client B] BSP that removed his 30 use to misuse and put in place by the process of the process of the day. [Client B] and safety skills and is not at an the community. Plan to continue to follow [client B's] atted 2/19/23 at 8:20 PM and became agitated for about 8:20 pm [client B] then sent A's] room and stole \$1 at then went back down stairs after found the process of the house about 8:50 pm. Per that addresses aggression ructive to property, socially offensive behavior, where the process of the house about 8:50 pm. Per that addresses aggression ructive to property, socially offensive behavior, where the property and the process of the house about 8:50 pm. Per that addresses aggression ructive to property, socially offensive behavior, where the property and the prope				

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	
		15G300	B. W	TNG		03/13	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			PIKE ST		
TRANSI	TIONAL SERVICES	S SUB LLC		MARTIN	NSVILLE, IN 46151		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY 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
		e way. Police were called and					
		to speak with [client B]. Once					
		n he got in staffs (sic) vehicle					
	_	d home. [Client B] has a BSP					
		ression towards others,					
		property, disruptive behavior,					
	•	behavior, uncooperative nt, and hyperactive behavior.					
		aff will continue to follow [client					
		actions between individuals for					
	health and safety."						
	incurrent unite surrosy.						
	An investigation da	ated 2/27/23 indicated, "[Client					
	B] was interviewed on 2/21/23. [Client B] stated						
	_	set because [client A] received					
	money for a drink	and he wanted one. [Client B]					
	stated that he walk	ed to the gas station and staff					
	[staff #10] attempt	ed to have him come back to the					
	Group Home. [Clie	ent B] stated that [Staff #10] met					
	_	on. [Client B] stated that [staff					
	_	not enter the gas station and					
		ner. [Client B] stated that the gas					
		ed him not to enter and to listen					
	_	B] stated that he ignored them					
		s station. [Client B] stated that					
	_	gas station staff nor make any					
		em. [Client B] stated that he got					
		e gas station and paid for it. nat he refused to ride home with					
	-	lking back to the group home.					
	_	nat the police stopped him and					
	-	t not leaving the group home					
	_	n. [Client B] stated that he					
	_	e group home after speaking					
	with the police.						
	[Stoff #5] was inte-	rviewed on 2/22/23. [Staff #5]					
		driving the van on an outing					
		viduals in the home. [Staff #5]					
		ced staff [staff #10] at the gas					
	Stated that She floth	ced starr [starr #10] at the gas					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G300		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/13/2023	
	ROVIDER OR SUPPLIER		110 W I	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151	
	SUMMARY: (EACH DEFICIEN REGULATORY OR station and watched stated that she did in himself into the gas when [Client B] left ride home. [Staff #5 [client B] speaking to him about not lea permission. [Staff # cooperative and retu further incident. [Staff #6] Program 2/23/23. [Staff #6] s from DSP [staff #1] group home and [sta convince [client B] #6] stated that [staff was refusing to retu the gas station after stated that it was re called and spoke to walking home. [Sta incidents were repo involving [Client B] [Staff #11] DSP, wa #11] stated that he w the night of 2/20/23 witnessed [client B] #10], DSP, followed stayed at the home of	SUB LLC STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LLSC IDENTIFYING INFORMATION [Client B] go inside. [Staff #5] ot witness [Client B] force station. [Staff #5] stated that it the gas station, he refused a is stated that she witnessed with the police and they spoke riving the group home without is stated that [Client B] was arm to the group home without Supervisor, was interviewed on stated that he received a report if that [client B] eloped from the aff #10] was attempting to to return to the home. [Staff if #11] reported that [client B] rn to the home and went into being told not to. [Staff #6] ported that the police were [client B] while he was iff #6] stated that no further reted to him that night]. as interviewed on 2/27/23. [Staff was working in the home on . [Staff #11] stated that he leave the home and [Staff d him. [Staff #11] stated that he with remaining individuals	110 W I	PIKE ST	(X5) COMPLETION DATE
	incident to [Staff #6 #11] stated that staf defiant and entered permission. [Staff # that [client B] refus were called. [Staff #	stated that he reported the [5], Program Supervisor. [Staff of told him that [Client B] was the gas station without [11] stated that staff told him ed a ride home and the police [511] stated that [Client B] did or incidents that evening.			

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

PRINTED: 05/08/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G300		A. BUII B. WIN	LDING	00	COMPL 03/13/	ETED	
NAME OF F	PROVIDER OR SUPPLIEF	\ \		STREET A	DDRESS, CITY, STATE, ZIP COD		
TRANSIT	TIONAL SERVICES	SUB LLC			ISVILLE, IN 46151		
(X4) ID		STATEMENT OF DEFICIENCIE	•	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		as interviewed on 2/27/23.		TAG	BEIGERETI		DATE
		nat [client B] became upset and					
		ne on 2/20/23. [Staff #10]					
	-	npted to get [client B] to come					
		Staff #10] stated that when					
	[Client B] refused,	she met him at the gas station.					
	[Staff #10] stated th	at the gas station attendant					
		[client B] was on his way.					
		at she told the gas station					
		tempt to get [client B] home as					
	he was there without permission. [Staff #10]						
	stated when [client B] arrived the gas station staff						
	told him not to enter and to go home with staff. [Staff #10] stated that [client B] ignored them and						
		on and bought a drink. [Staff					
	-	gas station staff asked her to					
	_	nich she did so. [Staff #10]					
	-] may have made slight					
	contact with the gas						
		itentional. [Staff #10] stated					
		ed to be transported home.					
	[Staff #10] stated th	nat [staff #5], DSP, arrived in					
		[client B] ignored her as well.					
		nat while [client B] was walking					
	-	rs stopped him and spoke with					
		ng the home without					
	-	10] stated that [Client B]					
	returned home with	out further incident.					
	Conclusion: It is su	bstantiated that [client B]					
		ne, it is unsubstantiated that					
	[client B] shoved th						
	D 1.0	C4-C5:111					
		Staff will be trained on acludes alone time each day for					
	•	be trained on incident					
		ion. Competed by [Regional					
	Director] 2/27/23."	ion. Competed by [Regional					
	The review indicate	ed there was no investigation					

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PRINTED: 05/08/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300		JILDING	INSTRUCTION 00	(X3) DATE COMPI 03/13	
	PROVIDER OR SUPPLIER			110 W F	DDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151		
(X4) ID PREFIX TAG	SUMMARY: (EACH DEFICIEN REGULATORY OR for the 2/5/23 and 2 elopement and his t review indicated the if staff followed clie behavior of agitatio elopement. The Area Director (at 10:00 AM. The A investigation for cli and 2/19/23. The A (investigation) for t stated the investigat Regional Director f The AD indicated tl thoroughly investig "incidents of eloper or not the client's B The Qualified Intell (QIDP)/Program Di 3/7/23 at 10:00 AM investigation should not staff neglected t QIDP/PD stated "th the investigation." This deficiency was failed to implement to prevent recurrence	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL RESC IDENTIFYING INFORMATION /19/23 incidents of client B's heft of client A's money. The e investigation did not address ent B's BSP to address his n which led up to the (AD) was interviewed on 3/7/23 AD indicated there was no ent B's elopements on 2/5/23 D stated, "I don't have one hose incidents." The AD tion was conducted "by the for [client B's] last elopement." he allegation was not ated. The AD stated ment should address whether SP was followed by staff." Rectual Disabilities Professional frector (PD) was interviewed on The QIDP/PD indicated the d have addressed whether or to follow client B's BSP. The here were some items left out of secited on 10/7/22. The facility a systemic plan of correction e.		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	Ε	(X5) COMPLETION DATE
W 0157 Bldg. 00	9-3-2(a) 483.420(d)(4) STAFF TREATME	ENT OF CLIENTS ation is verified, appropriate					

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corrective action must be taken.

Based on interview and record review for 2 of 3

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W 0157

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Program Director and Area

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04/28/2023

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		03/13/	/2023
		<u> </u>	1	CTDEET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER	8			PIKE ST		
TDANIGIT	IONAL SERVICES	SUBILIC			NSVILLE, IN 46151		
IRANSH	IONAL SERVICES	JUD LLC		IVIARTII	NOVILLE, IN 40101		
(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	<u> </u>	TAG	DEFICIENCY)		DATE
		ents A and B), the facility			Director will be trained on inci		
		rective measures were			reporting and investigations w		
		emented to address incidents			specific outcome of investigati	ons	
	of elopement for cli	ents A and B.			within 5 business days		
	<u> </u>				- Program Director and A		
	Findings include:				Director will be trained on ens	uring	
	1 751 6 111 -	65			recommendations from		
		reau of Developmental			investigations are completed		
		s (BDDS) reports were			- Area Director will meet		
	reviewed on 2/28/23 at 12:30 PM. The review				with Program Directors at leas		
	indicated the following:				weekly to discuss all incidents		
	A RDDS report dated 12/22/22 at 8:30 am				and investigations		
	A BDDS report dated 12/22/22 at 8:30 am indicated, "On 12/22/2022 about 6:30 AM [client				- All staff will be trained		
		-			incident reporting and notifying	-	
	_	ng that staff take him to the		management immediately after an incident			
		2 check that had arrived in the					
		veek. Staff informed [client A]			- All staff will be trained		
		open until about 8:30 AM and			Abuse and Neglect and Client		
	-	e him to the bank between 8:30			Rights		
		at 8:30 AM [client A] started			- Program Supervisor wi		
	-	If take him to the bank. Staff I take him as soon as they			monitor and address any issue		
	-				during home visits at least three	ee	
		ey were working on. [Client A] staff and said f you, I need			times per week		
		starr and said 1 you, I need without you then by my d			Program Director will monitor and address any issue	e in	
		exited the house. Staff			the home at least once weekly		
		ed the keys to the van and			during Site Supervisory visits	1	
		ient A]. While following			- Area Director will monit	or	
	0.	atedly prompted him to get in			at least once weekly during Si		
		old temperature and said that			Supervisory Visits		
		m to the bank. [Client A]					
	-	e van and continued walking in					
		bank. Once at the bank [client			Persons Responsible: Area		
		e drive thru window and			Director, Program Director,		
		fter cashing his check [client			Program Supervisor, Regional	I	
	A] still refused to get in the van with staff and				Director		
	instead walked to the gas station to buy himself						
		fter walking out of the gas					
	-	gain refused to get in the van					
		ed all the way home. [Client A]					

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G300		onstruction 00	(X3) DATE SURVEY COMPLETED 03/13/2023
	PROVIDER OR SUPPLIER FIONAL SERVICES SUB LLC	110 W I	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	arrived back at the house roughly 9:37 AM. While walking [client A] exhibited good pedestrian safety skills. [Client A] was within line of sight of staff the entire time that he was away from the house. The bank that [client A] uses is 2 blocks from his home and the gas station that he went to is roughly 9 blocks from away from his home. There were no further incidents for the remainder of the day. Staff will continue to follow [client A's] BSP (Behavior Support Plan) and encourage him to use his coping skills when he is upset." A BDDS report dated 2/10/23 at 12:30 PM indicated, "On 02/10/2023 [client A] left the group home about 12:30 pm and walked to the bank 2 blocks away without staff supervision. While at the bank [client A] attempted to access housemate [client B's] bank account using his [client B's] identification card. When unable to access the account [client A] returned home. [Client A] has a BSP (Behavior Support Plan) that addresses untrustworthy behavior and elopement. Plan to Resolve: Staff will continue to follow [client A's] BSP and an investigation has been initiated." An investigation dated 2/22/23 indicated, "[Client A] was interviewed on 2/21/23. [Client A] stated that he eloped from the house during the afternoon on 2/10/23. [Client A] stated that he took [client B's] identification card and went to the bank and attempted to withdraw money. [Client A] stated that he did not take his check and attempt to cash it. [Client A] stated that his staff [staff #4] and [staff #5] were working on 2/10/23. [Client A] stated that he told staff that he was going outside to vape and went to the bank. [Client A] stated that he bank is less than two blocks from the home. [Client A]			

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	СОМ	E SURVEY PLETED 3/2023
	PROVIDER OR SUPPLIER		110 W	ADDRESS, CITY, STATE, ZIP CO PIKE ST NSVILLE, IN 46151	D D	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION as gone for only ten minutes.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	stated that she was Group Home on 2/2 heard the door alars stated that she open A] vaping on the free that she went back [Staff #5] stated that cleaning and assisting room. [Staff #5] stated that cleaning to cash as identification. Whe she stated that [client A] denice and was standing in that [client A] denice stated that [client A] identification card. [Staff #4] was interestated that he was in A] went out the door #5] checked on him [Staff #4] stated that home. [Staff #4] stated that home after [Staff #4] stated that [client B's] identified [Staff #6] was interestated that [staff #5] elopement. [Staff #7] representative from [client A] attempted [client B's] identified [Staff #8] identified	viewed on 2/21/23. [Staff #5] working in the Martinsville 10/23. [Staff #5] stated that she in by the front door. [Staff #5] led the door and saw [client ont porch. [Staff #5] stated to the office to complete work. It other staff [staff #4] was ing other clients in the living ted that she received a phone claiming that [client A] was a check and had [client B's] in [staff #5] got off the phone, int A] had walked in the door in the kitchen. [Staff #5] stated ed leaving the home. [Staff #5] and walked in the door in the kitchen. [Staff #5] in [staff #4] stated that [staff #5] in the living room when [client for. [Staff #4] stated that [staff in and went back into the office. In the continued cleaning the lated that he saw [client A] walk approximately ten minutes. In [staff #5] informed him that stated [client A] was there. It [client A] denied having cation card. Viewed on 2/22/23. [Staff #6] in notified him of [client A's] 6] stated that he spoke with a the bank and they stated that d to cash [client B's] check with cation card. [Staff #6] stated ed having [client B's]				

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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	COMPI	LETED
		15G300	B. W	ING		03/13	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	8			PIKE ST		
TRANSIT	TIONAL SERVICES	SUB LLC		MARTI	NSVILLE, IN 46151		
(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	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		st but admitted to using it to woney. [Staff #6] stated that					
		• • •					
	[client A] returned the identification card but did not return the check. [Staff #6] stated that [client						
		times and believes he took the					
		6] stated that he is attempting					
	_	ity to cancel the check and get					
	a new one issued for [client B].						
	a new one issued for [enem B].						
	[Client B] was interviewed on 2/21/23. [Client B]						
	stated that he was not aware of [client A] taking						
	his identification card until it was returned. [Client						
	B] stated that he will keep it in his wallet for safe						
	keeping. [Client B]	stated that he was not angry					
	with [client A] and	enjoys living in the home with					
	him.						
	Conclusion: It is su	bstantiated that [client A] took					
		eation and Social Security check					
		sh it at the bank, it is also					
	substantiated that [c	client A] eloped from the home					
	for approximately to	en minutes.					
	Recommendations:	All staff retrained on [client					
		nent and stealing. Staff will join					
		when he vapes. Team will meet					
		it securing his identification					
		curing if requested. Team will					1
		al Security check for [client B]					
	_	if he is not able to obtain it.					
	Staff will observe in	ndividuals getting the mail to					
		als checks are received.					
	Completed by: [Reg	gional Director] 2/22/23."					
	The review of recor	ds indicated the facility did not					
		et due to staff not being aware					1
	that client A eloped from the home. The review						
	_	ndations made by the					
	investigator were no	<u>-</u>					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 00	COM	re survey ipleted 13/2023
	PROVIDER OR SUPPLIER		110 W I	ADDRESS, CITY, STATE, ZIP (PIKE ST NSVILLE, IN 46151	COD	
(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 CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	at 10:00 AM. The A conducted by a prev AD indicated the al investigated. The A should first look int neglectful in caring indicated recommen and implemented. To recommendations from the implemented yellow that this week." The Qualified Intell (QIDP)/Program Di 3/7/23 at 10:00 AM investigations trained investigations trained investigation was nestated "recommendations as possible so again." 2. The facility's Burn Disabilities Service reviewed on 2/28/2 indicated the follow A BDDS report data indicated, "On 02/0 eating his lunch hellow he was still hungry, and [client B] began and peers. [Client B over the ash tray on multiple times that home. Staff informed property that they we the staff were the or moment. About 12:	ectual Disabilities Professional rector (PD) was interviewed on . The QIDP/PD indicated he is ed. The QIDP/PD indicated the ot thorough. The QIDP/PD ations should be addressed as the action doesn't occur				

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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	NG		03/13/	2023
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	R			PIKE ST		
TRANSIT	IONAL SERVICES	SUBLIC			NSVILLE, IN 46151		
	TOTAL CENTROLS			1717 (1 (1 11	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	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ys going to to get drinks. At					
		d management and then call the					
		nent for assistance. Police met					
	[client B] at the nearby gas station. Police spoke with [client B] and bought him a fountain drink						
	and then drove him home. There were no further						
		nainder of the day. [Client B]					
		BSP that removed his 30					
	_	lue to misuse and put in place					
	where local law enforcement to be notified when						
		e home unsupervised. [Client					
		rian safety skills and is not at					
		in the community. Plan to					
	_	continue to follow [client B's]					
	BSP."						
	A BDDS report dat	ed 2/19/23 at 8:20 PM					
	indicated, "On 02/1	9/2023 about 8:00 pm [client B]					
		and became agitated for					
		About 8:20 pm [client B] then					
		ient A's] room and stole \$1					
	_	d then went back down stairs					
		Staff called [city] police for					
		[client B] after he eloped due					
	-	taff on shift at the time. Police					
		to the house about 8:50 pm.					
		P that addresses aggression					
	towards others, desi						
	-	, socially offensive behavior,					
	-	vior, elopement, and					
		or. Plan to Resolve: Staff met					
		aiting guardian approval. An					
	-	ng initiated on the missing					
	money."	ig initiated on the illissing					
	money.						
	A BDDS report dat	ed 2/20/23 at 8:30 PM					
	_	/23 about 8:30 PM [client B]					
		unknown reasons and left the					
	-	ed [client B] in a vehicle to a					
		-					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	
		15G300	B. WI	NG		03/13/	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				PIKE ST		
TRANSIT	IONAL SERVICES	SUB LLC			NSVILLE, IN 46151		
			T		,		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	REFERENCED TO THE APPROPRIATE DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION		TAG	BEFREINCT)		DATE
		house. [Client B] forced his					
		pushing the gas station					
	attendant out of the way. Police were called and came to the station to speak with [client B]. Once						
		he got in staffs (sic) vehicle					
		home. [Client B] has a BSP					
	_	ession towards others,					
	destructive (sic) to property, disruptive behavior,						
	socially offensive behavior, uncooperative						
	behavior, elopement, and hyperactive behavior.						
		ff will continue to follow [client					
	B's] BSP and interactions between individuals for						
	health and safety."						
		ted 2/27/23 indicated, "[Client					
		on 2/21/23. [Client B] stated					
	_	et because [client A] received					
	-	nd he wanted one. [Client B]					
		d to the gas station and staff					
		d to have him come back to the					
		nt B] stated that [Staff #10] met					
	_	on. [Client B] stated that [staff					
	_	ot enter the gas station and					
		er. [Client B] stated that the gas d him not to enter and to listen					
		B] stated that he ignored them					
	_	station. [Client B] stated that					
	_	gas station staff nor make any					
	_	n. [Client B] stated that he got					
		gas station and paid for it.					
		at he refused to ride home with					
		king back to the group home.					
		at the police stopped him and					
		not leaving the group home					
	_	[Client B] stated that he					
	-	group home after speaking					
	with the police.						
		viewed on 2/22/23. [Staff #5]					
	stated that she was	driving the van on an outing					
			1				l .

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	(X2) MULTII A. BUILDI B. WING		NSTRUCTION 00	(X3) DATE : COMPL 03/13/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 110 W PIKE ST MARTINSVILLE, IN 46151					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREI TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	stated that she notice station and watched stated that she did in himself into the gas when [Client B] left ride home. [Staff #5 [client B] speaking to him about not lead permission. [Staff #6 cooperative and retifurther incident. [Staff #6] Program 2/23/23. [Staff #6] staff #1 group home and [staconvince [client B] #6] stated that [staff was refusing to return the gas station after stated that it was recalled and spoke to walking home. [Staff incidents were repositively incident by the repositively incident to [Staff #11] incident to [Staff #11] incident to [Staff #6 #11] incident to [Staf	iduals in the home. [Staff #5] ed staff [staff #10] at the gas [Client B] go inside. [Staff #5] ot witness [Client B] force station. [Staff #5] stated that it the gas station, he refused a is stated that she witnessed with the police and they spoke wing the group home without 5] stated that [Client B] was arn to the group home without Supervisor, was interviewed on stated that he received a report 1] that [client B] eloped from the aff #10] was attempting to to return to the home. [Staff if #11] reported that [client B] rn to the home and went into being told not to. [Staff #6] ported that the police were [client B] while he was iff #6] stated that no further red to him that night]. as interviewed on 2/27/23. [Staff was working in the home on . [Staff #11] stated that he leave the home and [Staff d him. [Staff #11] stated that he with remaining individuals stated that he reported the inj, Program Supervisor. [Staff if told him that [Client B] was the gas station without 11] stated that staff told him and a ride home and the police if 11] stated that [Client B] did						

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

PRINTED: 05/08/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G300		A. BUILDI B. WING	NG <u>00</u>		COMPL 03/13/	ETED	
NAME OF	PROVIDER OR SUPPLIEF			REET ADDRESS, C O W PIKE ST	CITY, STATE, ZIP COD		
TRANSI	TIONAL SERVICES	SUB LLC		ARTINSVILLE,	, IN 46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION r incidents that evening.	ID PREI TA	TIX (EACH C CROSS-R	COVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	[Staff #10], DSP, w [Staff #10] stated the eloped from the hore stated that she attent back to the home. [I [Client B] refused, a [Staff #10] stated the asked [staff #10] stated the staff that she will at the was there without stated when [client told him not to entered the gas stated that the call the police in which stated that [client B] contact with the gas staff but it was uning that [client B] refus [Staff #10] stated the van to assist but [Staff #10] stated the van to assist b	ras interviewed on 2/27/23. rat [client B] became upset and me on 2/20/23. [Staff #10] rapted to get [client B] to come Staff #10] stated that when she met him at the gas station. rat the gas station attendant [client B] was on his way. rat she told the gas station ratempt to get [client B] home as at permission. [Staff #10] B] arrived the gas station staff rand to go home with staff. rat [client B] ignored them and for and bought a drink. [Staff gas station staff asked her to nich she did so. [Staff #10]] may have made slight a station ratentional. [Staff #10] stated ed to be transported home. rat [staff #5], DSP, arrived in a [client B] ignored her as well. rat while [client B] was walking restopped him and spoke with rate home without [10] stated that [Client B] out further incident.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 15G300 03/13/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 110 W PIKE ST 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 PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE The review indicated there was no investigation for the 2/5/23 and 2/19/23 incidents of elopement and theft of client A's money. The review indicated the investigation did not address if staff followed client B's BSP to address his behavior of agitation which led up to the elopement. The Area Director (AD) was interviewed on 3/7/23 at 10:00 AM. The AD indicated there was no investigation for client B's elopements on 2/5/23 and 2/19/23. The AD stated, "I don't have one (investigation) for those incidents." The AD stated the investigation was conducted "by the Regional Director for [client B's] last elopement." The AD indicated the allegation was not thoroughly investigated. The AD stated "incidents of elopement should address whether or not the client's BSP was followed by staff." The AD stated, "Abuse, neglect, exploitation (ANEM) allegations, pretty much all incidents in some form require an investigation." The AD stated there have been 3 different Program Directors in the last 4 months and she just took over as AD so "things have been dropped, investigations have been missed or can't be found." The AD stated investigations should include corrective measures such as "training, follow up, and staff observations." The Qualified Intellectual Disabilities Professional (QIDP)/Program Director (PD) was interviewed on 3/7/23 at 10:00 AM. The QIDP/PD stated investigations are "different levels, at the lower level, we handle, as it escalates, QI (Quality) comes in and facilitates." The QIDP/PD indicated the investigation should have addressed whether or not staff neglected to follow client B's BSP. The QIDP/PD stated "there were some items left out of

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the investigation." The QIDP/PD stated

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIE		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SO				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		15G300	B. W	ING		03/13/	2023
	ROVIDER OR SUPPLIER		•	110 W I	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	happening again" ar should always be pu This deficiency was failed to implement	cited on 10/7/22. The facility a systemic plan of correction					
	to prevent recurrence. This federal tag relates to complaint #IN00384168.						
	This federal tag relates to complaint #IN00384168. 9-3-2(a)						
W 0159	483.430(a) QIDP						
Bldg. 00	be integrated, coo a qualified intellect who- Based on observation interview for 3 of 3 C) and three addition Qualified Intellectual (QIDP) failed to interview for 3 of 3 communication systems of the clients' program communication systems from the day program and fair training objectives where the communication systems include: 1) Please refer to W sample (A, B and C and H), the QIDP facommunication systems in the communication systems are communication systems.	iled to ensure client E's	W	0159	- Home staff will be train on completing the communica book and ensuring it is taken to Day Program daily - Day Program staff will be trained on completing communication book - Specifically for Client Ethe IDT will meet to discuss objectives and ensure proper implementation - All staff will be trained of all clients ISPs and BSPs - Program Director and A Director will be trained on ensuall proper documentation is completed and in the home - Program Supervisor will monitor at least three times weekly during home visits	tion o be on Area uring	04/28/2023
	*	249. For 1 additional client failed to ensure client E's			Program Director will monitor and address any issue	es in	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/13/2023
	PROVIDER OR SUPPLIER		110 W	ADDRESS, CITY, STATE, ZIP COD PIKE ST INSVILLE, IN 46151	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	failed to implement to prevent recurrence	s cited on 10/7/22. The facility a systemic plan of correction ee.		the home during weekly Site Supervisory visits - Area Director will monitor through weekly Site Supervisor Visits	
	This federal tag rela	ates to complaint #IN00384168.		Persons Responsible: Area Director, Program Director, Program Supervisor, Behaviori	ist
W 0249 Bldg. 00	formulated a clien each client must retreatment program interventions and number and frequachievement of th	erdisciplinary team has t's individual program plan, eceive a continuous active n consisting of needed services in sufficient ency to support the e objectives identified in the			
	interview for 1 additacility failed to ensobjectives were imposed include: Observations were on 2/28/23 from 4:43/1/23 from 6:30 At at 4:50 PM, client E with the door closed prompted to the din #7. At 5:15 PM, afthis room and closed came out of his room the bathroom by stawent back to his room and closed the start of the start	on, record review and tional client (client E), the sure client E's training	W 0249	- The IDT will meet to discuss Client E's objectives at active treatment schedule to ensure they are appropriate - Staff will be trained on a updated objectives for Client E - Program Director and Program Supervisor will be trained on ensuring objectives and all active treatment are being completed for all clients in the home - Staff will be trained on active treatment and following objectives for all clients in the home - Program Supervisor will monitor at least three times weekly during home visits	ined

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 15G300 B. WING 03/13/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 110 W PIKE ST TRANSITIONAL SERVICES SUB LLC MARTINSVILLE, IN 46151 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE 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 observation period at 7:45 PM. Program Director will monitor and address any issues in On 3/1/23 at 6:30 AM client E was in his room in the home at least once weekly bed with the door closed and remained in his room during Site Supervisory visits until the end of the observation at 9:10 AM without staff prompting him to an activity. Client E's record was reviewed on 3/2/23 at 2:00 Persons Responsible: Area PM. Client E's 10/2/22 Behavior Support Plan Director, Program Director, (BSP) indicated, "...[Client E] is not employed, and Program Supervisor completes day programming at the group home. [Client E] requires constant supervision throughout the day. [Client E] can communicate by using simple words and phrases, and gestures. [Client E] needs assistance with completing activities of daily living. [Client E] enjoys swimming, writing, riding in the van, jumping, taking a bath, and exercising. [Client E] can become obsessive over things, which can result in extreme physical aggression towards self and others, and property destruction. Many of [client E's] behaviors occur as a result of him obsessing." Client E's 4/28/22 Individual Support Plan (ISP) indicated he had the following training objectives: "-Daily, [Client E] will go to the dining room for med pass. -[Client E] will participate in a community outing at least 3 times per week. -Daily, [Client E] will practice one sign to increase his communication with others. -Bimonthly, [Client E] will withdraw from his bank account and sign his name to the withdrawal. -Daily, [Client E] will put his clothes and bedding in the washer. -Daily, [Client E] will take a drink and/or wipe his mouth with a napkin in between bites of food." Staff #5 was interviewed on 2/28/23 at 6:30 PM. Staff #5 stated client E is "home everyday" and

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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		03/13/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R			PIKE ST		
TRANSI	TIONAL SERVICES	SUBLIC			NSVILLE, IN 46151		
	ı				10 10 10 10 10 10 10 10 10 10 10 10 10 1		
(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	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		y program. Staff #5 stated					
	-	verything" and is "2 to 1 when					
		ty." Staff #5 stated client E					
		nmunity a few times a week"					
	and he "loves ball". Staff #5 stated for client E's						
	training goals "he will do things with prompting,						
	but only if he's in the mood."						
	Staff #7 was interviewed on 3/1/23 at 6:30 AM.						
	Staff #7 stated client E "went to day program for a						
		stimulated him and he had					
		aff #7 stated staff "try" to get					
	client E out in the community "he likes the park,						
	van rides, fast food, he loves to swing and play						
		d client E's training objectives					
		se he will only do what he					
	wants to do."	,					
	Staff #2 was intervi	ewed on 3/1/23 at 8:00 AM.					
	Staff #2 indicated c	lient E has goals of "putting					
	his dirty clothes in	the hamper, taking his meds,					
	and wiping his mou	th when eating." Staff #2					
	_	to get him to come out of his					
		we can get him to sit on the					
	_	ted "it's difficult to get him to					
		m, he will come out to eat, if it					
		to do, he won't do it." Staff #2					
	-	lays in his bed". Staff #2					
		da" goes on outings in the					
	_	2 elaborated and stated "he					
	_	cause he's destroyed the [gas					
		rant] in the past causing					
		s of damage." Staff #2 stated					
	_	to the park to swing" and he					
	likes "van rides, especially speed bumps." Staff #2						
	stated "on occasion" staff will take client E "to						
	[restaurant], it's his favorite."						
	On 3/7/23 at 10:00	AM the Area Director (AD) was					
		D stated "the clients' plans					
	micrylewed. The A	D sauce the elicitis pialis					

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	(X2) MULTIPLE C A. BUILDING B. WING	onstruction ((X3) DATE SURVEY COMPLETED 03/13/2023	
	PROVIDER OR SUPPLIEI		110 W	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE SCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION ." The AD indicated staff	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 0368 Bldg. 00	should follow clien On 3/7/23 at 10:00 interviewed. The R training with staff of indicated client E's This deficiency was failed to implement to prevent recurrent 9-3-4(a) 483.460(k)(1) DRUG ADMINIST The system for dr assure that all dru compliance with the Based on record res sampled clients (cli additional clien	t E's plan. AM the Regional (RD) was D stated "we need to do more on clients' plans. The RD plan should be followed. s cited on 10/7/22. The facility that a systemic plan of correction cee.	W 0368	- Nurse will complete a medication review in the home ensure that all medications are present and are following Physicians Orders - Program Supervisor will trained on ensuring all medications are present and to notify nursing and managemen any issues with medications oc - Nurse and Program Supervisor will ensure that all medication refills are correct, ordered in a timely manner, and are given to clients correctly - All staff will be trained or medication administration - Program Supervisor will monitor at least three times per week during home visits	be t if ccur	

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tab (last administered on 10-07-2022), Linzess

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Program Director will

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M				X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		15G300	B. W	ING		03/13/	/2023
				CTREET A	ADDRESS CITY STATE ZID COD		
NAME OF P	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD PIKE ST		
TDANCIT	TIONIAL SERVICES	SUBLIC					
TRANSH	TIONAL 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 APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	(stomach) 145 MG	cap (missed dosages			monitor and address any issue	es in	
	10-09-2022 and 10-	10-2022), Xifaxan (antibiotic for			the home at least one time pe	r	
	intestines) 550 MG	tab (last administered on			week during Site Supervisory	visits	
	10-05-2022). Pharmacy has sent refill request orders to [Primary Care Provider (PCP)] who is				- Nurse will monitor at least		
					twice weekly during home visi	ts	
	[client E's] PCP, last request was sent on						
	10-10-2022 via fax. [Program Director] went to						
	[PCP's] office and spoke with office staff and left a						
		cation refills. PCP office stated			Persons Responsible: Area		
		busy and that it would take			Director, Program Director,		
	72 hours for them to	o send the refill order to the			Program Supervisor, Nurse		
	pharmacy. [Client E] isn't showing any adverse						
	effects for not being administered the listed						
	medications. Plan to Resolve: [Program Director]						
		ow up with [PCP's] office daily					
	about refill orders b	eing sent to the pharmacy."					
		ed 10/2/22 at 8:00 am indicated,					
		was brought to [Program					
	_	that [client C] had not been					
		llowing medications:					
		sychotic) 20 mg tablet (last					
		/3/2022), Lamotrigine (for					
		(last administered on					
		ultivitamin (supplement) tablet					
		2022). [Pharmacy] sent refill					
		lient C's] PCP, [PCP]. These					
		10/10/2022. [Program Director]					
		ice, spoke with office staff, and					
		medication refills. The PCP's					
		ave been busy, and it could					
		for refill orders to be sent to					
		ent C] has not been showing					
	any adverse effects						
	_	s] nurse called and spoke with					
	DSP [Staff #2]. The nurse, [Nurse], stated she						
	would do her best to get the order sent to						
		end of the day. Additionally,					
		Aripiprazole is not prescribed					
	by [PCP]. The MAR (medication administration						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G300		· /	JILDING	instruction 00	(X3) DATE COMPL 03/13/	ETED			
		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 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)	ΓE	(X5) COMPLETION DATE	
		[Psychiatric Mental (PMHNP)] in [City spoke with a call ce [client C] is not in t [Program Director] [PCP's] office daily sent to [Pharmacy]. continue to reach or Aripiprazole prescribused in the quantity is a property of the missed evening medication audit at discovered that on a given his evening medication are discovered. The program nurse discovered. The program nurse discovered. The program nurse discovered up to the time will continue to mo safety. Plan to Resonurse will continue and safety. The program date indicated, "On 11/1 B] is out of the folic HCL (for anxiety) 2 taken 1 x (time) dail home staff, and [PD requesting the medication that the medication of the mistory of the mistory of the folic HCL (for anxiety) 2 taken 1 x (time) dail home staff, and [PD requesting the medication that the medication of the medication that the medication of the medication of the folic HCL (for anxiety) 2 taken 1 x (time) dail home staff, and [PD requesting the medication that the medication of the medication that the medication of the medication of the medication that the medication of the medication	prazole is prescribed by Health Nurse Practitioner , State]. [Program Director] enter representative who stated he system. Plan to Resolve: will continue to follow up with regarding refill requests being [Program Director] will at to [PMHNP] regarding the iption. Additionally, [Program benting a nightly medication bed daily and PRN (as needed) th client, which will alert staff s low." ed 11/11/22 at 8:00 PM 2/2022 staff was conducting a [client D's] home, and it 11/11/2022, [client D] was not nedication consisting of (for overactive bladder) 20 mg. was notified as soon as it was ogram nurse instructed staff to for signs of adverse side effects ing medication and none were to of this report. Staff and nurse nitor [client D] for health and olive: The Mentor staff and to monitor [client D] for health gram nurse will compete a tion and training with staff." ed 11/15/22 at 7:52 PM 5/22, [PD] was informed [client owing medication; Guanfacine 20 mg. This medication is to be ly per [PCP]. [Pharmacy], group D) have called [PCP] office fication be refilled. Plan to continue to reach out to [PCP's]						

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 03/13/2023			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 110 W PIKE ST MARTINSVILLE, IN 46151					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR office until the med	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION ication is refilled and brought	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
	A BDDS report data indicated, "On 11/1 C] is out of the folk (antipsychotic) 20m (antidepressant) 50 stabilizer) 25 mg. T daily per [PCP]. [Pf [PD] have called [P medication be refill continue to reach or medication is refilled home." A BDDS report data indicated, "On 11/1 H] is out of the folk (supplement) 1,000 medication is to be [Pharmacy], group called [PCP's] office refilled. Plan to Reservach out to [PCP's] refilled and brought A BDDS report data indicated, "On 11/2 medication audit, and 11/27/2022 several medications. [Clien medication consisting (antipsychotic) 20 m. Rosuvastatin (for his A] was not given his mg and [client E] w. (antipsychotic) 200 symptoms) 145 mg	ed 11/15/22 at 7:52 PM 5/22, [PD] was informed [client owing medication: Aripiprazole ag, Desvenlafaxine ER mg, Lamotrigine (mood his medication is to be taken 1 x narmacy], group home staff, and CP's] office requesting the ed. Plan to Resolve: [PD] will at to [PCP's] office until the ad and brought to the group ed 11/15/22 at 7:52 PM 5/22, [PD] was informed [client owing medication: Vitamin B 12 meg (micrograms). This taken 1 x daily per [PCP]. home staff, and [PD] have e requesting the medication be olve: [PD] will continue to office until the medication is to the group home." ed 11/27/22 at 8:00 PM 7/2022 staff was conducting a and it discovered that on individuals did not receive their tD] was not given his evening						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G300	B. W	ING		03/13/	/2023
NAME OF T	DROWNED OF CLIPPLIES			STREET A	ADDRESS, CITY, STATE, ZIP COD		
	PROVIDER OR SUPPLIER				PIKE ST		
TRANSIT	TIONAL SERVICES	SUB LLC		MARTIN	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)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DETICIENC!)		DATE
		overed. The program nurse nonitor all individuals for signs					
		cts of the missed evening					
		_					
	medication and none were noted up to the time of this report. Staff and nurse will continue to						
	monitor for health a						
		ne Mentor staff and nurse will					
		all for health and safety. The					
		complete a medication					
	observation and trai						
		8					
	A BDDS report date	ed 2/7/23 at 8:00 AM indicated,					
	"On 02/07/2023 while Program Director was						
	completing an audit	t of the Medical Administration					
		it was discovered that [client					
	_	ollowing medication					
		ood) 25 MG Tablet. According					
		C] had not been administered					
		rom the 1st through the 7th of					
] has an appointment					
		Psych on February 22nd to					
	_	the pharmacy. [Client C] has					
		adverse effects from not					
	_	medications. Staff will check					
		ensure scripts were received					
		tigation has been initiated to					
	determine the cause	of the medication errors."					
	A BDDS report date	ed 2/7/23 at 8:00 AM indicated,					
	"On 02/07/2023 wh	ile Program Director was					
	completing an audit	t of the Medical Administration					
	Record at the home	it was discovered that [client					
	E] was out of the fo	llowing medications, Docusate					
	CAL 240 MG Soft	gel (stool softener),					
		MG Tablet (supplement),					
		4 MG Capsule (for enlarged					
	prostate) and Xifaxa	an 550 MG Tablet (antibiotic					
	for the intestines). A	According to the record [client					
	E] had not been adn	ninistered these medications					
	from the 1st through	h the 7th of February. [Client					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	(X2) MULT A. BUILD B. WING		NSTRUCTION 00	(X3) DATE : COMPL 03/13/	ETED
	PROVIDER OR SUPPLIEF		1	10 W P	DDRESS, CITY, STATE, ZIP COD PIKE ST ISVILLE, IN 46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	medication refills for [Client E] has not end from not being adm Resolve: Staff will ensure scripts were investigation has because of the medical						
	indicated clients A,	acility's BDDS reports B, C, D, E and H did not ations as prescribed by the					
	Staff #7 stated "we	ewed on 3/1/23 at 7:15 AM. (DSPs) order the meds, most they are not here when we are ll the supervisor."					
	3/1/23. The CI state for meds and then ye and then get in trou	view (CI) was conducted on ad "we call the doctor's office we call to let management know ble." The CI went on to say "I we don't have the tools we such as meds."					
	at 10:00 AM. The A in the mandatory Coorientation and ther just took over as the started doing audits quality department we are re-training a	AD) was interviewed on 3/7/23 AD stated "all staff are trained ore A and Core B in new hire annually." The AD stated "I e AD, I know the last AD of medications and the completed an investigation so Il staff on Core A and Core B." elients' medications "should be scribed."					
	interviewed on 3/7/	tered Nurse (RN) was 23 at 11:00 AM. The RN stated ould have a label with the					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	ľ	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 03/13/	ETED		
	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 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)	ATE	(X5) COMPLETION DATE		
TAG	clients name and m "staff should be che removing them." The document injection MAR." The RN inc B trained. The RN inc should always mak are in the home bef stated the clients! "o when not receiving The RN stated clien be available becaus always be followed The Core B Indiana (DSP) Training dat 3/7/2023 at 9:00 Al following, "Medi administering medi use of the medication medication as a res of medication admi occur when:Medi doctor's order: Indi medicationsDirec Acquiring Needed As a DSP, it is imp individual does not possibly resulting in agency's policy for medications from the may notify you that any more refills. The needs a new script of practitioner to conti- from the pharmacy agency's policy for new script from the The most important	edication information" and ecking for expired meds and he RN stated staff should sites by "noting it on the dicated all staff are Core A and stated "staff in the home es ure the clients medications for they run out." The RN could have had severe issues "their prescribed medications. In their prescribed medications. In their prescribed medications ephysician's orders "should always ephysician's orders "should always ephysician's orders "should ." In Direct Support Professional ed 6/9/2020 was reviewed on M. The review indicated the cation errors are any error while cations that results in incorrect on or an incorrect omission of a sult of not following the 6 rights inistration. Medication errors cation omission without a widual runs out of the Support Professional Role in Medications for Individuals: cortant to ensure that your run out of medications in a missed dose. Follow your when to order more the pharmacyThe pharmacy is the individual does not have his means that the individual to be sent in by the inue to get more medication. DSPs need to know their how to address acquiring a practitioner for more refills. It thing to remember as a DSP is		TAG	DEFICIENCY		DATE		
	to ensure that you a	re familiar with your agency's							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G300		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/13/2023	
	PROVIDER OR SUPPLIE		110 W	ADDRESS, CITY, STATE, ZIP COD PIKE ST INSVILLE, 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
	your individual in a	iring all needed medications for a timely manner." s cited on 10/7/22. The facility			
	_	t a systemic plan of correction			
W 9999	9-3-6(a)				
Bldg. 00					
	State Findings		W 9999	- The operation is in the process of hiring an Office	04/28/2023
	460 IAC 9-3-2(c)(3 State Findings	3) Resident Protections		Coordinator who is responsiblemployee files being current - Area Director and Progoriectors will be trained on	
	its employment pra person would be er conviction of a crir dependent populati provider shall obta motor vehicles rece authorized in IC 5- P.L.2-2003, Section IC 10-13-3-27.], ar verification of emp	provider shall demonstrate that actices assure that no staff imployed where there is: (3) me substantially related to a on or any violent crime. The in, as a minimum, a bureau of ord, a criminal history check as 2-5-5 [IC 5-2-5 was repealed by in 102, effective July 1, 2003. See add three (3) references. Mere aloyment dates by previous to constitute a reference in is section.		ensuring employee files are up date when an Office Coordina not present - An audit of employee fi will be conducted to ensure the all items are current - Once an Office Coording is hired, a tracking sheet will be put into place to track all employees files to monitor any expirations that can be address in a timely manner	tor is les at nator pe
	Based on record re sampled staff (staff failed to ensure sta	view and interview for 3 of 3 ff #1, #2 and #3), the facility fff #1 and #3 had a valid driver's to ensure staff #2 and #3 had 3		Persons Responsible: Area Director, Program Director, Program Supervisor	

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

PRINTED: 05/08/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 15G300	A. BUILDING 00 B. WING		COMP	COMPLETED 03/13/2023	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 110 W PIKE ST				
TRANSI	TIONAL SERVICES	SUB LLC	MA	RTINSVILLE, IN 46151			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	review indicated the Staff #1's file had a expired 6/11/2018. Staff #2's file had n Staff #3's file had a expired on 4/8/2022 references present. On 3/7/23 at 10:00 was interviewed. The driving records show then annually to ensure AD indicated it was for reporting issues being expired or sustaff was hired. The care of it (reference are supposed to list recruiters to call, the one, we have a coup The AD indicated the coordinator to assist The AD stated, "it is to print out the reference and place had an office coord. The Regional Direct 3/7/23 at 11:00 AM had a policy regard. Vehicle checks and.	copy of a driver's license that o references present. a copy of a driver's license that 2. Staff #3's file had no AM, the Area Supervisor (AD) he AD indicated the staffs' uld be checked upon hire and sure they remain valid. The sthe responsibility of the staff with their licenses such as spended. The AD indicated the duct motor vehicle checks after e AD stated, "recruiters take ss." The AD stated employees 3 to 5 references for the at way if we can't get a hold of the of back-ups if they list 5." here has been no office t with the new hire paperwork. s the office coordinator's job rences emailed by the in their file and we haven't inator for over 6 months." Ator (RD) was interviewed on The RD indicated the facility ing staff Bureau of Motor reference checks. Cited on 10/7/22. The facility a systemic plan of correction					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/13/2023		
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP COD 110 W PIKE ST MARTINSVILLE, IN 46151				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	I	PREFIX			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	9-3-2(c)(3)						

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