STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G331	A. BUILDING 00 B. WING	03/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PALADIN, INC	1709 FARRAND AVE LA PORTE, IN 46350

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W 0000 Bldg. 00	This visit was for the post certification revisit (PCR) to the investigation of complaints #IN00249030 and #IN00250085 completed on 1/24/18. This visit was in conjunction with a full recertification and state licensure survey. This visit included the investigation of complaint #IN00256623. Complaint #IN00249030: Not corrected. Complaint #IN00250085: Not corrected. Survey Dates: March 20, 21, 22, and 23, 2018. Facility Number: 000849 Provider Number: 15G331 AIM Number: 100243820 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 and #28194 on 4/4/18.	W 0000		
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on observation, record review, and interview for 1 of 4 allegations of abuse, neglect, and/or injury of unknown source reviewed, the facility failed to conduct a thorough investigation in regards to an incident of elopement of client A. Findings include:	W 0154	**W154-** To correct the deficiency now and for the future of all potential participants of alleged incidents of abuse, neglect, mistreatment, unknown injury and incidents with potential harm such as elopement will continue to be reported per	04/20/2018

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

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	The facility's Bureau of Developmental Disabilities Services (BDDS) reportables and investigations were reviewed on 3/20/18 at 3:02 PM. Review of the facility's BDDS reportables indicated the following (not all inclusive): -BDDS reportable dated 3/12/18 indicated, "On the night of 3/11/18, [client A] went to her bedroom without incident. After a few minutes, she went into the garage to sit. Staff checked on her and she stated that she wanted to be left alone and not talk to anyone. She came back into the house and asked to be alone in the backyard. Staff performed visual checks often. When staff performed another visual check, they realized that [client A] was not in the backyard. Two staff went to look for [client A] and she was out of staff's sight for approximately 15 minutes. Staff found her down the road behind a parked car. The neighbors called 911 as [client A] was complaining of right hand pain. Paladin staff transported [client A] to the ER (Emergency Room) where she was treated and discharged. She was diagnosed with a sprained wrist and instructed to wear a PRN (as needed) brace for comfort. Plan to Resolve (Immediate and Long Term): Staff will keep [client A] in their site (sic) at all times when [client A] is in the backyard. Staff will continue to follow her elopement plan in the event that [client A] should elope again." Review of the BDDS reportable and email statement indicated the facility did not have an investigative report with findings of the investigation and conclusions and/or recommendations. Review of documentation for the 3/11/18 indicated there was no documentation of the following:		guidelines of BQIS Incident Reporting; as well as thoroughly investigated in a timely manner. Paladin Procedure has been updated **(#500.05 & #500.06- SEE ATTACHED**) to include the initial steps to start the investigation and who is to be involved and the use of the new investigation packet. Care Coordinators will continuously follow up with all questions regarding the incident and gather the information first. All incidents will be reported by staff immediately to the Care Coordinators/Program Managers, OR whom responsible in the absence of either the Care Coordinator/Program Manager, such as Director, which was the case during the elopement. They will then immediately initiate the investigation procedure and gather the investigation team, comprised of the Care Coordinator, Program Manager, Director and Corporate Compliance Officer that would use the new investigation packet/report (**SEE ATTACHED***)* to be completed timely, thorough and consistent investigation. Care Coordinator/ or whom responsible will collect all initial facts, documents and staff statements to bring to the team. All information will then be reviewed and investigated until the team feels that they have completed a comprehensive and detailed	

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	-Which staff were working at the time of the incident and their training status on client A's plans -Statements and/or interview from staff that were working at the time of the incident -Statements and/or interview from client A and/or clients B, C, D, and E -Indication of how often the visual checks were conducted, as indicated in the reportable -Indication of how long client A was out of staff's sight -Investigation to determine how client A may have sprained her wrist -To determine if client A's Behavior Support Plan (BSP) was implemented as written and/or if staff were in need of retraining -To determine if client A's BSP required any revision. Care Coordinator (CC) #1 was interviewed on 3/21/18 at 2:37 PM. Interview with CC #1 indicated the following (not all inclusive): -When asked what incidents should be investigated, CC #1 stated, "Anything that needs more knowledge." -When asked if an investigation had taken place in regard to the 3/11/18 incident, CC #1 indicated he was not sure. -When asked what happened on 3/11/18, CC #1 stated, "I was on vacation. She (client A) was agitated. Sometimes she will walk outside. She wants to be left alone. Staff need to keep her in eye sight and be there. She was out front then out back (in the backyard). Staff couldn't find her and followed her route she normally takes. Sometimes she will run into items like parked cars or grab trees. Maybe it's for extra attention. I believe a neighbor called 911. Staff found her 10-15 minutes later. Staff was there and tried to explain to people.		investigation. Follow up questions or re-interviews may be added if needed after initial interviews. All staff and individuals will be sure to be interviewed for vital information. In person is preferred but phone may be acceptable depending on circumstances. Then after the investigation, the HR manger will assist in the findings to determine action that needs to take place such as training, disciplinary or termination. Each incident will be reviewed by the IR committee monthly to ensure that all investigations were completed and thorough. The IR committee includes Care Coordinators, Compliance coordinator and Program Manager/Director. The Safety Committee will then review quarterly and take any recommendations from the IR committee. They may then determine if any further changes/updates may need to take place. If so, the Corporate Compliance Officer would update the procedure and/or Investigation packet/report. As well, our new internal incident reports through our documentation/tracking system(Provide/Accel Trax) will be ready to use to contact responsible parties through email with detailed information needed for the investigation. Elopement will be an option to select and	

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	She went to the ER." -When asked how client A's BSP addressed elopement, CC #1 stated, "It's a target behavior. Definitely be aware of it. It increased in the last year. They need to be there and be aware of her whereabouts. We want to give her space and want to be respectful when she says leave me alone. (Staff) need to be there. When she does take off, staff are to follow her and use calming techniques. They can call me, her mom, or [name of other group home in the area]. She will usually come back within 10-15 minutes. Usually trying to get away from staff. Just for safety, stay with her." -When asked how client A should be supervised in the home, CC #1 stated, "In the home, know where she is. She has boundaries in the home and outside. They have to know her whereabouts." -When asked how client A should be supervised if she is in the backyard, CC #1 stated, "She should be supervised with staff. They should be out there with her. The plan states (staff) should be out there. If she can be watched through the door, you'd need to be right there watching. They need to know her whereabouts, plain and simple. Have eyes on her and be there with her." -When asked what staff should do if they cannot find client A, CC #1 stated, "They should check her route, check the house, garage, check the community, as well as contacting the person on call. If we can't see her, not sure if we have a time frame of when to call the police or what to do." -When asked if client A's BSP indicated what staff should do in the event staff cannot find client A, CC #1 indicated it did not. CC #1 stated, "We had elopement plans in place (in the past), but she had gotten better and it was charged. It was just put back into the plan. It is not in there. It should be added in there and how to handle the situation. It's probably in an old one." -When asked if staff supervised client A		further give details on the incident. This will increase timeliness to start investigation and limit any loss of paperwork to get to the office/team members. Which is also situation that happened in this case. Statements/documentations were lost and found days later. This should be ready by 5/1/18.	

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	according to her plan, CC #1 stated, "No. Should have had continuous eye sight." -When asked how often visual checks were as documented in the reportable, CC #1 stated, "If it didn't state, I don't know. I don't know if they have any more documentation. I would have to ask [Residential Director (RD) #1]. We should definitely have the staff point of view/documentation. Their statement, to make sure they matched, make sure that they were following the plan accordingly." At the time of exit, no additional information was provided to the survey. This deficiency was cited on 1/24/18. The facility failed to implement a systemic plan of correction to prevent recurrence. This federal tag relates to complaints #IN00249030 and #IN00250085. 9-3-2(a)			
W 0240 Bldg. 00	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on record review and interview for 1 of 3 sampled clients (A), the client's Individual Program Plan (IPP) and/or Behavior Support Plan (BSP) failed to indicate what facility staff should do when client A eloped and staff were unable to locate her. Findings include: The facility's Bureau of Developmental Disabilities Services (BDDS) reportables and investigations	W 0240	**W240-** To correct this deficiency now and in the future for those affected or could have been affected, Paladin has updated/revised the individuals BSP- with the target behavior of elopement. The individuals BSP has been updated and trained to staff on 4/12/18. It now not only indicates what to do if she does leave but if she has left and is out	04/20/2018

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	were reviewed on 3/20/18 at 3:02 PM. Review of the facility's BDDS reportables indicate the following (not all inclusive): -BDDS reportable dated 3/12/18 indicated, "On the night of 3/11/18, [client A] went to her bedroom without incident. After a few minutes, she went into the garage to sit. Staff checked on her and she stated that she wanted to be left alone and not talk to anyone. She came back into the house and asked to be alone in the backyard. Staff performed visual checks often. When staff performed another visual check, they realized that [client A] was not in the backyard. Two staff went to look for [client A] and she was out of staff's sight for approximately 15 minutes. Staff found her down the road behind a parked car. The neighbors called 911 as [client A] was complaining of right hand pain. Paladin staff transported [client A] to the ER (Emergency Room) where she was treated and discharged. She was diagnosed with a sprained wrist and instructed to wear a PRN (as needed) brace for comfort. Plan to Resolve (Immediate and Long Term): Staff will keep [client A] in their site (sic) at all times when [client A] is in the backyard. Staff will continue to follow her elopement plan in the event that [client A] should elope again." Client A's record was reviewed on 3/21/18 at 10:44 AM. Client A's 10/25/17 Individual Support Plan (ISP) and/or record indicated client A's diagnoses included, but were not limited to, Mild Intellectual Disability, Impulse Control Disorder, Epilepsy, and Psychogenic Seizures. Client A's 11/17 Behavior Support Plan (BSP) indicated client A's targeted behaviors included verbal aggression,		of eyesight. **(SEE Revised- BSP)** Staff have several options to work with her if they know her whereabouts and now how to handle the situation but if she is out of sight and whereabouts are unknown. Staff will utilize and follow BSP to have members of IDT assist as well as other group homes nearby; as well as local authorities if needed to assist. Other individuals that could have been affected by this behavior, their BSPs have been reviewed if elopement was a target behavior. These were discussed to staff at all staff meeting. At this time, no one else has a need for an elopement risk plan or added to BSP. BSPs are also available to review on the Accel Trax and back-up book. The back-up book is used in case of a power outage/loss of internet. Care Coordinator will be sure to update at least annually and as needed due to change /behavior status. IDT will review behaviors at monthly meetings and Care Coordinator reviews data monthly to report progress during Psych appointments for any possible adjustments. DSMs will ensure that staff have access and BSPs are available to staff as needed.	

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	physical aggression, and elopement. Client A's BSP defined elopement as "leaving the safe boundaries specified unannounced and unsupervised." Client A's BSP indicated the following (not all inclusive) in regard to elopement: -"1. [Client A] has increased this behavior over the last year with attempting to elope or successful eloping... -4. If [client A] is upset and wants to go outside. Do not argue it or bring lots of attention to that. Redirect to a better choice - a quiet/spare room, bedroom; go downstairs with her, staff/supervisor office. Inform other staff/supervisor. If still insisting let her to go but we must go out with her or have eyes on her for safety. She must be in eyesight at all times. Always communicate with other staff/supervisor to be ready to act if need be... -5. If [client A] leaves supervised boundaries, staff will calmly, ask her 'What you doing?'/'Where you going?' (sic) ask if she wants to talk and to remember to express her feelings as an adult. Just find out what the situation is. She may want to talk and she may not. Respect those wishes. Staff would need to be with her if leaving the boundaries... -6. If bystanders interfere, do not give personal information out. Remember HIPAA (health insurance portability and accountability act). Ignore bystanders and let them know you work with her and have it under control and attempt to leave area. If they will not move or interfere with your assistance to [client A], call 911... -Safe Boundaries Group Home: The backyard, the fence line as if it would extend around the property and the front yard sidewalk are the boundaries as well as close to the street, staff should be close/next to her to be able to react."			

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	Review of client A's BSP indicated there was no documentation in regard to what facility staff should do when client A eloped and staff were unable to locate her. Care Coordinator (CC) #1 was interviewed on 3/21/18 at 2:37 PM. Interview with CC #1 indicated the following (not all inclusive): -When asked how client A's BSP addressed elopement, CC #1 stated, "It's a target behavior. Definitely be aware of it. It increased in the last year. They need to be there and be aware of her whereabouts. We want to give her space and want to be respectful when she says leave me alone. (Staff) need to be there. When she does take off, staff are to follow her and use calming techniques. They can call me, her mom, or [name of other group home in the area]. She will usually come back within 10-15 minutes. Usually trying to get away from staff. Just for safety, stay with her." -When asked how client A should be supervised in the home, CC #1 stated, "In the home, know where she is. She has boundaries in the home and outside. They have to know her whereabouts." -When asked how client A should be supervised if she is in the backyard, CC #1 stated, "She should be supervised with staff. They should be out there with her. The plan states (staff) should be out there. If she can be watched through the door, you'd need to be right there watching. They need to know her whereabouts, plain and simple. Have eyes on her and be there with her." -When asked what staff should do if they cannot find client A, CC #1 stated, "They should check her route, check the house, garage, check the community, as well as contacting the person on call. If we can't see her, not sure if we have a time frame of when to call the police or what to do."			

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	-When asked if client A's BSP indicated what staff should do in the event staff cannot find client A, CC #1 indicated it did not. CC #1 stated, "We had elopement plans in place (in the past), but she had gotten better and it was charged. It was just put back into the plan. It is not in there. It should be added in there and how to handle the situation. It's probably in an old one." -When asked if staff supervised client A according to her plan, CC #1 stated, "No. Should have had continuous eye sight." This deficiency was cited on 1/24/18. The facility failed to implement a systemic plan of correction to prevent recurrence. This federal tag relates to complaints #IN00249030 and #IN00250085. 9-3-4(a)			