STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED
711.D I DAIN	o. conduction	15G331	B. WING		04/16/2018
			_		
NAME OF	PROVIDER OR SUPPLIEI	R		ADDRESS, CITY, STATE, ZIP COD ARRAND AVE	
PALADI	N, INC			RTE, IN 46350	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	1	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	1	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
E 0000					
Bldg					
			E 0000		
		paredness Survey was			
	_	ndiana State Department of			
	Health in accordance	ce with 42 CFR 483.475.			
	Survey Date: 04/10	6/18			
	Survey Bate. 61/10	0/10			
	Facility Number: (	000849			
	Provider Number:	15G331			
	AIM Number: 100	243820			
	1	Preparedness survey, Paladin,			
		n compliance with Emergency irements for Medicare and			
		ting Providers and Suppliers, 42			
	CFR 483.475	ting Froviders and Suppliers, 42			
	The facility has 6 c	ertified beds. All 6 beds are			
	certified for Medica	aid. At the time of the survey,			
	the census was 5.				
	O III D	1 . 1 . 04/10/10 DA			
	Quality Review coi	mpleted on 04/18/18 - DA			
	The requirement at	42 CFR, Subpart 483.475 is			
	NOT MET as evide				
E 0018					
Bldg	D 1 1	11.4 1 1 6 114			0.7 (0.1 (0.01.0)
		view and interview, the facility ergency preparedness policies	E 0018	E-018—Tracking Procedures	05/31/2018
		lude a system to track the		The facility has developed a means to track Participants and	,
	_	staff and sheltered clients in		on-duty staff in the facility's care	
	1	's care during and after an		during an emergency even. In t	
		uty staff and sheltered clients		event Participants and staff are	
	1	g the emergency, the ICF/IID		relocated, the facility will	
		nent the specific name and		document the specific name an	id

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

TITLE

(X6) DATE

Any defiency statement 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 disclodays 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.

PRINTED: 05/02/2018 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G331	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/16/2018
NAME OF F	PROVIDER OR SUPPLIEF		1709 F	ADDRESS, CITY, STATE, ZIP COI FARRAND AVE RTE, IN 46350	)
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE COMPLETION DATE
TAG	location of the recein accordance with deficient practice of Findings include:  Based on record rev Supervisor on 04/10 p.m., no policies an system to track the sheltered clients in during and after an review. Based on in review, the Mainter	iving facility or other location 42 CFR 483.475(b)(2). This build affect all occupants.  view with the Maintenance 6/18 between 1:10 p.m. and 1:26 d procedures which include a location of on-duty staff and the ICF/IID facility's care emergency was available to ance Supervisor confirmed no a was available to review.	TAG	location of the receiving Below are documents the used in the tracking proceed Participants and staff.  PARTICIPANT EVACUAT TRACKING FORM  Sending Facility:  ——  Receiving Facility: ——  Participant Name: (PRING) ——  Date of Birth: ——  //	facility. at will be redures for  ATION  NT)  "Female air  "YES
	I		Ī	1	i

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D1VO21

Facility ID: 000849

If continuation sheet

Page 2 of 47

PRINTED: 05/02/2018 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES  DF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G331	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/16/2018
NAME OF P	ROVIDER OR SUPPLIEF	₹	1709 F	ADDRESS, CITY, STATE, ZIP COD ARRAND AVE RTE, IN 46350	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
IAU	REGULATORY OF	A LOC IDENTIFICING INFURMATION	IAG	Primary Diagnosis:  MASTER PARTICIPANT EVACUATION TRACKING LO INCIDENT NAME OPERATIONAL PEROD  DATE: FROM: TO: TIME: FROM: TO: PARTICIPANT EVACUATION INFORMATION PARTICIPANT NAME	
				YES NO	

PRINTED: 05/02/2018

	Γ OF HEALTH AND HU R MEDICARE & MEDIC				FORM APPROVED OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G331	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 04/16/2018	
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODFARRAND AVE		
PALADIN	N, INC		LA PO	RTE, IN 46350		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	TAG REGULATORY OR LSC IDENTIFYING INFORMATI	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	G REGULATORY OR LSC IDENTIFYING INFORMATION		DISPOSITION MODE OF TRANSPORT ACCEPTING FACILITY NAME & CONTACT INFO TIME FACILITY CONTACTED REPORT GIVEN TRANSFER INITIATED (TIME TRANSPORT CO.) MEDICATION SENT YES NO MD/FAMILY NOTIFIED YES NO HOME FACILITY TRANSFER TEMP. SHELTER			
				ARRIVAL CONFIRMED YES NO PARTICIPANT NAME  MED RECORD SENT YES NO DISPOSITION MODE OF TRANSPORT ACCEPTING FACILITY NAME & CONTACT INFO		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D1VO21 Facility ID: 000849

REPORT GIVEN

TRANSPORT CO.) **MEDICATION SENT** 

TRANSFER INITIATED (TIME/

If continuation sheet

Page 4 of 47

### DEI CEN

PRINTED: 05/02/2018

PARTMENT OF HEALTH AND HUMAN SERVICES					
NTERS FOR MEDICARE & MEDICA	AID SERVICES		OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY		

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER  15G331	A. BUILDING B. WING	<del></del>	COMPLETED 04/16/2018
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD ARRAND AVE	
PALADIN	, INC			RTE, IN 46350	
(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
				YES NO	52
				MD/FAMILY NOTIFIED YES NO HOME FACILITY TRANSFER TEMP. SHELTER	
				ARRIVAL CONFIRMED YES NO PARTICIPANT NAME	
				MED RECORD SENT YES NO  DISPOSITION MODE OF TRANSPORT ACCEPTING FACILITY NAME & CONTACT INFO TIME FACILITY CONTACTED REPORT GIVEN TRANSFER INITIATED (TIME TRANSPORT CO.)	
				MEDICATION SENT YES NO MD/FAMILY NOTIFIED YES NO HOME FACILITY TRANSFER TEMP. SHELTER	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D1VO21 Facility ID: 000849

If continuation sheet

Page 5 of 47

PRINTED: 05/02/2018 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES  DF CORRECTION	IDENTIFICATION NUMBER  15G331	A. BUILDING B. WING	JNSTRUCTION	COMPLETED 04/16/2018
NAME OF P	ROVIDER OR SUPPLIER		1709 F	ADDRESS, CITY, STATE, ZIP COD ARRAND AVE RTE, IN 46350	
(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)	ON (X5) DBE COMPLETION DATE
				ARRIVAL CONFIRMED YES NO PREPARED BY PRINT NAME: SIGNATURE:	
				DATE/TIME: FACILITY:	
				ON-DUTY STAFF EVACUATRACKING LOG STAFF NAME DESTINATION DATE & TIME DEPARTED ARRIVAL CONFIRMED	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D1VO21

Facility ID: 000849

If continuation sheet

Page 6 of 47

PRINTED: 05/02/2018 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DEF CORRECTION (IDENTIFICATION NUMBER) 15G331	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE COMPL <b>04/16</b> /	ETED
NAME OF P	ROVIDER OR SUPPLIER	1709 F	ADDRESS, CITY, STATE, ZIP COD ARRAND AVE RTE, IN 46350		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON DBE DPRIATE	(X5) COMPLETION DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D1VO21

Facility ID: 000849

If continuation sheet

Page 7 of 47

PRINTED: 05/02/2018 FORM APPROVED OMB NO. 0938-039

CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G331	î ´	ILDING	ONSTRUCTION	(X3) DATE S COMPL <b>04/16</b> /	ETED
NAME OF I	PROVIDER OR SUPPLIER	2		1709 F	ADDRESS, CITY, STATE, ZIP COD ARRAND AVE RTE, IN 46350		
(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)	TE	(X5) COMPLETION DATE
E 0020							
Bldg	failed to ensure emand procedures includes considerat needs of evacuees; transportation; iden location(s); and princommunication with assistance in according	view and interview, the facility ergency preparedness policies ude information for safe e ICF/IID facility, which ion of care and treatment staff responsibilities; tification of evacuation mary and alternate means of h external sources of lance with 42 CFR 483.475(b) practice could affect all	E 00	020	E-020—Evacuation Plan This evacuation procedure is written so that there are clear guidelines for providing client a staff safety in the event of a disaster. At the time of a disast it is imperative that the Administrator be contacted in order to give staff proper direct it is important to know that each situation is going to be different and that a situation may not all	etion. ch nt,	05/31/2018

FORM CMS-2567(02-99) Previous Versions Obsolete

Findings include:

Event ID:

D1VO21

Facility ID: 000849

If continuation sheet

for the following procedure to be

implemented in this specific order.

Page 8 of 47

PRINTED: 05/02/2018 FORM APPROVED OMB NO. 0938-039

	of correction (X1) Provider/supplier/clia (IDENTIFICATION NUMBER (15G331)	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/16/2018
NAME OF I	PROVIDER OR SUPPLIER	1709 F	ADDRESS, CITY, STATE, ZIP COD ARRAND AVE RTE, IN 46350	
(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
	Based on record review and interview on 04/16/18 between 1:10 p.m. and 1:26 p.m., the Maintenance Supervisor confirmed no policies and procedures which include information for safe evacuation from the ICF/IID facility, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance was available for review.		In the event of an emergency, shall immediately be called. A calling 911, the Program Manshould be called to give further instructions. If there is loss of power, staff will use their cell phones as an alternate source communication.  When evacuating, the Red Bi must accompany the staff. The binder includes the face sheer risk plans for each participant well as copies of the tracking Transportation  This facility is equipped with a transportation van capable of transporting clients. If addition transportation is needed, Palahas a transportation departme with vans that are equipped to handle those who are in wheelchairs. The Transportatic Coordinator will be contacted, informed of the emergency, assistance will be given.  Participant Tracking The Participant Evacuation Tracking log (see above) will be used to identify the location of each participant. As a means alternate communication, cell phones will be available wheth may be staff's personal cell phones, or company cell phor that have been distributed to end of the company cell phores of the company cell phores of company cell phores.	ffer ager er e
E 0022				
Bldg				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D1VO21 Facility ID: 000849

If continuation sheet Page 9 of 47

PRINTED: 05/02/2018 FORM APPROVED OMB NO. 0938-039

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u></u>	COMPLETED
		15G331	B. WING		04/16/2018
			STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF F	PROVIDER OR SUPPLIEF	8		ARRAND AVE	
PALADIN	N, INC			RTE, IN 46350	
(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	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		view and interview, the facility	E 0022	E-022—Sheltering in Place	05/31/2018
		ergency preparedness policies		Plan	
	_	ude a means to shelter in place		Sheltering in place is when yo	
		d volunteers who remain in the		choose to stay in your facility t	
		accordance with 42 CFR		wait out a disaster. Sometime	S,
	483.475(b)(4). This	deficient practice could affect		your facility is the safest place	
	all occupants.			be. This is a precaution aimed	•
				keep you safe while remaining	·
	Findings include:			indoors. (This is not the same	
				thing as going to a shelter in o	ase
		view and interview on 04/16/18		of a storm). Shelter-in-place	
		and 1:26 p.m., the Maintenance		means selecting a small, inter	l l
		ed no policies and procedures		room, with no or few windows	, and
		mation about a means to		taking refuge there.	
	_	clients, staff, and volunteers		· Close and lock all window	NS
		CF/IID facility was available for		and exterior doors.	
	review.			If you are told there is da	- I
				of explosion, close the window	1
				shades, blinds, or curtains.	
				Quickly locate supplies y	
				may need such as food, water	,
				radio, etc.	
				Go to the interior room	
				without windows that is above	
				ground level. In the case of a	
				chemical threat, an above-gro	
				location is preferable because	
				some chemicals are heavier the	
				air, and may seep into basem	
				even if the windows are closed	J.
				It is ideal to have a	.om
				hard-wired telephone in the ro	
				you select. Call your emergen	Cy
				contact and have the phone	_
				available if you need to report	•
				life-threatening condition. Cell	uiai
				telephone equipment may be	ing
				overwhelmed or damaged dur	III I
	1		1	an emergency.	1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D1VO21

Facility ID: 000849

If continuation sheet

Keep listening to your radio

Page 10 of 47

PRINTED: 05/02/2018 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G331	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMI	e survey Pleted 6/2018
NAME OF P	ROVIDER OR SUPPLIE	ER .	1709 F	ADDRESS, CITY, STATE, ZIP ARRAND AVE RTE, IN 46350	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ORRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
				or television until you safe or you are told to Local officials may ca evacuation in specific greatest risk in your content of the Your Vehicle:  If you are driving a vehear advice to "shelte the radio, take these shoulding, go there immediated place recommendation place you pick described by the road. Stop your vestigned by the road of the endicated by the road of the endicated by the endicate	evacuate.  Il for areas at ommunity.  hicle and ar-in-place" on steps: lose to a public nediately and shelter-in ans for the ped above. It to get to a kly and to the side of ehicle in the lif it is sunny e to stop shady spot, ated. In and ents. It the neg vents with it or egularly and are until you et back on at some or traffic directions of ials.  Il for areas at ommunity.  In the neg to a step is a st	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D1VO21 Facility ID: 000849

If continuation sheet

Page 11 of 47

PRINTED: 05/02/2018 FORM APPROVED OMB NO. 0938-039

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING		COMPLETED	
		15G331	B. W	ING		04/16/2018	
	DOLUMBER 0		<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				ARRAND AVE		
PALADIN	I, INC			LA POF	RTE, IN 46350		
(X4) ID	SUMMARY S	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	REGULATORY OR	LSC IDENTIFYING INFORMATION	1	TAG	DEFICIENCY)		DATE
					Following their instructions	_	
					during and after emergencies	S	
					regarding sheltering, food,	io	
					water, and clean-up methods your safest choice.	15	
					Remember that instructions to		
					shelter-in-place are usually		
					provided for durations of a few	,	
					hours, not days or weeks. The		
					little danger that the room in w		
					you are taking shelter will run		
					of oxygen and you will suffoca		
E 0024							
51.1							
Bldg	D 1 1						0.7/24/2010
		riew and interview, the facility	E 00	024	E-024—Use of Volunteers	1	05/31/2018
		ergency preparedness policies			During an emergency, the faci	-	
	-	ude the use of volunteers in ner emergency staffing			may need to accept volunteer support from individuals with		
		the process and role for			varying levels of skills and trai	nina	
		or Federally designated health			In the event that this does occ	_	
	•	address surge needs during			volunteers will be paired with		
	-	cordance with 42 CFR			from the facility. Non-medical		
	- ·	leficient practice could affect all			volunteers would perform		
	occupants.	•			non-medical tasks. Volunteers	will	
	-				sign in and they will be tracked		
	Findings include:				during the emergency as the		
					Participants and staff will be.		
		iew with the Maintenance					
	_	6/18 between 1:10 p.m. and 1:26					
		d procedures which include					
		s in an emergency or other					
		strategies was available for					
		terview at the time of record					
		ance Supervisor confirmed no					
	such documentation	was available for review.					

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: D1VO21 Facility ID: 000849 If continuation sheet

PRINTED: 05/02/2018 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  15G331			JILDING	INSTRUCTION	COMPL 04/16/	ETED	
NAME OF I	PROVIDER OR SUPPLIER			1709 F	ADDRESS, CITY, STATE, ZIP COD ARRAND AVE RTE, IN 46350		
(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 APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
E 0026							
Bldg	failed to ensure eme and procedures incl facility under a wair in accordance with a provision of care an care site identified be officials in accordant. This deficient practive. Findings include:  Based on record rev. Supervisor on 04/16 p.m., no policies and the role of the ICF/1 declared by the Section 1135 of the Based on interview the Maintenance Su	riew and interview, the facility ergency preparedness policies ude the role of the ICF/IID over declared by the Secretary, section 1135 of the Act, in the ditreatment at an alternate by emergency management nee with 42 CFR 483.475(b)(8). ite could affect all occupants.  Friew with the Maintenance 6/18 between 1:10 p.m. and 1:26 di procedures which include IID facility under a waiver retary, in accordance with Act was available for review. at the time of record review, pervisor confirmed no such available for review.	E 00	026	E-026—Role under Section 1 During an emergency, the faci may need to relocate to an alternate site set forth by an emergency official. The facility continue to give care, eliciting help of others, while still meeti the waiver requirements of the Participants. If this facility were deemed as the alternate site, either the CEO, Vice Presiden Participant services, and/or the Corporate Compliance Officer would be available 24 hours a to ensure the minimal disruption regulations, policies and procedures of the agency. The of this facility will be to pair up work in conjunction with a particular person who meets the waiver criteria to ensure each person continues to receive th care needed/	will the ng to day on to e role and	05/31/2018
E 0032							
Bldg	failed to ensure the communication plan alternate means for following: (i) ICF/I State, tribal, regional management agencia	riew and interview, the facility emergency preparedness in includes (3) Primary and communicating with the ID facility's staff (ii) Federal, al, or local emergency ties in accordance with 42 CFR deficient practice could affect	E 00	032	E-029 through E-035—Communication Plan Disasters can occur at any giv time. All employees listed belo will be all hands on deck. A disaster requires the assistanc all Group Home staff and administration. The President/CEO will assume responsibility for coordinating	en w	05/31/2018

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D1VO21 Facility ID: 000849

If continuation sheet Page 13 of 47

PRINTED: 05/02/2018 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  I OF CORRECTION IDENTIFICATION NUMBER  15G331	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING	(X3) DATE SURVEY  COMPLETED  04/16/2018
NAME OF	PROVIDER OR SUPPLIER  N, INC	STREET ADDRESS, CITY 1709 FARRAND AV LA PORTE, IN 4635	/E
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PROVIE PREFIX (EACH CORR CROSS-REFER	DER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)  CX5)  COMPLETION DATE
	Findings include:  Based on record review and interview on 04/16/18 between 1:10 p.m. and 1:26 p.m., the Maintenance Supervisor confirmed no documentation about the communication plan which included (3) Primary and alternate means for communicating with the following: (i) ICF/IID facility's staff (ii) Federal, State, tribal, regional, or local emergency management agencies was available for review.	absence, fit Participant responsibil information Emergency will be shall family durin process an conference involved in are as follod 1. Bill Trowbridge Bill.Trowbridge Bill.	e—President/CEO, ridge@paladin.care, 3888. erly Latchford—Vice of Participant Services, ford@paladin.care (219)  na Smith—Human Manager, nith@paladin.care (708)  ey Gant—Director of al Services, nt@paladin.care, (219)  Rupe—Program Jeff.Rupe@paladin.care 1561. s Mitchell—Direct entor, chell@paladin.care ca Jackson—Direct

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D1VO21 Facility ID: 000849

If continuation sheet Page 14 of 47

PRINTED: 05/02/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE (	CONSTRUCTION (X3) DATE SURVEY	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING	COMPLETED		
15G331 B. WING	04/16/2018		
STRFF:	Γ ADDRESS, CITY, STATE, ZIP COD		
I NAME OF PROVIDER OR SUPPLIER	FARRAND AVE		
	DRTE, IN 46350		
	·		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (X5)		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX	CROSS-REFERENCED TO THE APPROPRIATE	ON	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG	DATE		
	9. Brittany Latchford—Direct		
	Support Mentor,		
	Brittany.Latchford@paladin.care		
	10. Ray Wolff—Direct Support		
	Mentor, Ray.Wolff@paladin.care  11. Curtis Jackson—Direct		
	Support Mentor,		
	Curtis.Jackson@paladin.care		
	12. Direct Support Staff (See		
	Staff Roster)		
	13. Jimmy Kuta—Maintenance		
	Supervisor,		
	Jimmy.Kuta@paladin.care, (219)		
	851-7844.		
	14. Shalanda		
	Robinson—Corporate Compliance		
	Officer,		
	Shalanda.Robinson@paladin.care		
	(219) 688-1055.		
	15. Marjory Watson—Nursing		
	Staff,		
	Marjory.Watson@paladin.care		
	(219) 362-2710 (7a-7p) or (219)		
	608-1875.		
	16. Other Staff Designated as		
	Needed by the President/CEO		
	External Contacts:		
	1. EMERGENCY911		
	2. Fire Department—(219)		
	362-3456		
	3. Police		
	Non-Emergency—(219) 362-9446		
	4. Poison Control—(800)		
	222-1222 5 NIDSCO (gas look		
	5. NIPSCO (gas leak		
	emergency)—(800) 634-3524		
1 1	6 Sonting Alarm Company /		
	6. Sentinel Alarm Company—( 219) 874-6051		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D1VO21

Health

Facility ID: 000849

If continuation sheet

Page 15 of 47

PRINTED: 05/02/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING	<del></del>	COMPLETED		
		15G331	B. WING		04/16/2018	
NAME OF D	ROVIDER OR SUPPLIE	D	STREET	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF P	ROVIDER OR SUPPLIE	ĸ		FARRAND AVE		
PALADIN	I, INC		LA PO	RTE, IN 46350		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	•	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG	REGULATORY O.	R LSC IDENTIFYING INFORMATION	TAG		DATE	
				(ISDH)— <u>https://gatewayp.isdhov or incidents@isdh.in.gov</u> , (		
				233-1325	317)	
				8. Indiana Bureau of		
				Developmental Disability Serv	rices	
				(BDDS)—		
				BQIS.Help@fssa.IN.gov, (877	<b>'</b> )	
				218-3059		
				9. Indiana Protection and		
				Advocacy—(317) 722-5555		
				10. La Porte Hospital—(219) 326-1234		
				11. Local Health		
				Department—(219) 326-6808		
				12. La Porte County Emergei		
				Management—(219) 898-149	1	
				13. State Emergency		
				Management Agency—(317)		
				232-3980 14. Federal Emergency		
				Management Agency—(312)		
				408-5500		
				15. InTouch Pharmacy—(877	<b>'</b> )	
				464-7055		
				16. Primary Physician—Maur		
				Panares (219) 304-6100 and	Nicki	
				Alexander (219) 878-5046	_	
				17. Dungarvin Indiana LLC (L Porte County)—(326-6277) ar		
				Opportunity Enterprise (Porte		
				County)—(219) 464-9621		
				If there is an emergency and	staff	
				would need to get a hold of or		
				the above and the phone is no		
				working, staff will use their cel		
				phones as an alternate source	e for	
				communication. Each DSM	3,40,0	
				(Direct Support Mentor) will have company cell phone to	ave d	
				communicate with emergency	,	
			1	I	1	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D1VO21 Facility ID: 000849

If continuation sheet Page 16 of 47

PRINTED: 05/02/2018 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G331	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 	(X3) DATE SURVEY  COMPLETED  04/16/2018
NAME OF PI	ROVIDER OR SUPPLIE	R	1709 F	ADDRESS, CITY, STATE, ZIP CO ARRAND AVE RTE, IN 46350	OD
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	RECTION (X5) OULD BE PPROPRIATE COMPLETION DATE
	TAG REGULATORY OR LSC IDENTIFYING INFORMATION		officials and any other administrative staff. The method of choice for medial documentation in Participant Face Sheets below: PARTICIPANT FACE SPARTICIPANT	is through a . See	
				WHOM TO NOTIFY WI EMERGENCIES AND PROBLEMS Contact Name Phone Alt. Phone Primary Representative	
				Secondary Contact #1	
				Any restrictions on no MENTAL HEALTH STA Cognitive or Psychiatric/Behaviora Disorders: (please list) FUNCTIONAL STATUS Ambulation	ATUS

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D1VO21 Facility ID: 000849

If continuation sheet Page 17 of 47

PRINTED: 05/02/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G331		(X2) MULTIPLE C A. BUILDING B. WING	<del></del>	(X3) DATE SURVEY COMPLETED 04/16/2018	
NAME OF P	ROVIDER OR SUPPLIE I, INC	R	1709 F	r address, city, state, zip cod FARRAND AVE DRTE, IN 46350	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  ¿ Independent  Incontinent Self-Feeding Bathing Other Independent, Assisted: ¿ Cane, Walker, Wheelchair Urine ¿	(X5) COMPLETION DATE
				Supervision  Supervision  Confined to Bed or Confin	Chair
				Special Diet  ¿ Dysphagia ¿ Mech Soft ¿ Fluid restrictions ¿ Infection ¿ Contact precautions ¿ Respiratory Precautions	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D1VO21 Facility ID: 000849

If continuation sheet Page 18 of 47

PRINTED: 05/02/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G331		A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/16/2018	
NAME OF P	PROVIDER OR SUPPLIE	R	1709	r address, city, state, zip cod FARRAND AVE DRTE, IN 46350	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)  Other special care needs:	(X5) COMPLETION DATE	
				Below is the document that we used to provide information at the facility's needs and its ab to provide assistance to the authority have jurisdiction (locand State emergency management agencies, local state public health department the Incident Command Center Emergency Operations Center designee). The occupancy of facility will affect its ability to provide assistance.  Occupancy and Assistance Document Date:	about ility  cal  and nts, er, the er, or f the
				Facility Name:	
				Type of Facility:	
				Maximum Census:	
				Occupancy Percentage:	
				# of Beds Occupied:	
				Needs of the Facility:	
				"None "Food "Water "	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $D1VO21 \qquad {\it Facility ID:} \quad 000849$ 

If continuation sheet

Page 19 of 47

PRINTED: 05/02/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G331  NAME OF PROVIDER OR SUPPLIER  PALADIN, INC		(X2) MULTIPLE CO A. BUILDING B. WING	<u></u>	ODATE SURVEY COMPLETED 04/16/2018
		1709 F	ADDRESS, CITY, STATE, ZIP COD FARRAND AVE RTE, IN 46350	
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Medical Supplies "Assistance with Evacuation and transfers	
E 0033				
Bldg	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (4) A method for sharing information and medical documentation for clients under the ICF/IID facility's care, as necessary, with other health care providers to maintain the continuity of care; (5) A means, in the event of an evacuation, to release client information as permitted under 45 CFR 164.510(b) (1)(ii); (6) A means of providing information about the general condition and location of clients under the facility's care as permitted under 45 CFR 164.510(b)(4) in accordance with 42 CFR 483.475(c) (4). This deficient practice could affect all occupants.  Findings include:  Based on record review with the Maintenance Supervisor on 04/16/18 between 1:10 p.m. and 1:26 p.m., no documentation was available for a communication plan which includes (4) A method for sharing information and medical documentation for clients under the ICF/IID facility's care, as necessary, with other health care providers to maintain the continuity of care; (5) A means, in the event of an evacuation, to release client information as permitted under 45 CFR 164.510(b)(1)(ii); (6) A means of providing	E 0033	E-029 through E-035—Communication Plan Disasters can occur at any given time. All employees listed below will be all hands on deck. A disaster requires the assistance of all Group Home staff and administration. The President/CEO will assume responsibility for coordinating emergency actions. In case of his absence, the Vice President of Participant Services will assume responsibility. Appropriate information regarding the Emergency Preparedness Plan will be shared with clients and family during the Admission process and annually during case conferences. Persons that will be involved in these emergency plan are as follows:  1. Bill Trowbridge—President/CEO, Bill.Trowbridge@paladin.care, (219) 510-3888. 2. Kimberly Latchford—Vice President of Participant Services, Kim.Latchford@paladin.care	of S S S
	information about the general condition and location of clients under the facility's care. Based		898-5841. 3. Alanna Smith—Human	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D1VO21 Facility ID: 000849

If continuation sheet Page 20 of 47

PRINTED: 05/02/2018 FORM APPROVED OMB NO. 0938-039

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING			COMPLETED			
		15G331	B. W	ING		04/16	/2018	
				_	_			
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD			
					ARRAND AVE			
PALADIN	N, INC			LA POF	RTE, IN 46350			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWING BY AN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	T-	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	AIE.	DATE	
		time of record review, the			Resource Manager,			
	Maintenance Super				Alanna.Smith@paladin.care (	708)		
	-	available for review.			646-4242	,		
					4. Kelsey Gant—Director of	f		
					Residential Services,			
					Kelsey.Gant@paladin.care, (2	219)		
					309-5186.	- /		
					5. Jeff Rupe—Program			
					Manager, <u>Jeff.Rupe@paladin</u>	.care		
					(574) 305-1561.			
					6. James Mitchell—Direct			
					Support Mentor,			
					James.Mitchell@paladin.care			
					7. Jessica Jackson—Direct	-		
					Support Mentor,			
					Jessica.Jackson@paladin.car	e		
					8. Tara Payton—Direct Sup			
					Mentor,	•		
					Tara.Payton@paladin.care			
					Brittany Latchford—Direct	ct		
					Support Mentor,			
					Brittany.Latchford@paladin.ca	are		
					10. Ray Wolff—Direct Suppo			
					Mentor, Ray.Wolff@paladin.c			
					11. Curtis Jackson—Direct	<del></del>		
					Support Mentor,			
					Curtis.Jackson@paladin.care			
					12. Direct Support Staff (See			
					Staff Roster)			
					13. Jimmy Kuta—Maintenand	се		
					Supervisor,			
					Jimmy.Kuta@paladin.care, (2	19)		
					851-7844.	•		
					14. Shalanda			
					Robinson—Corporate Compli	ance		
					Officer,			
					Shalanda.Robinson@paladin.	.care		
					(219) 688-1055.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D1VO21

Facility ID: 000849

Staff,

If continuation sheet

15. Marjory Watson—Nursing

Page 21 of 47

PRINTED: 05/02/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G331		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/16/2018	
NAME OF PE	ROVIDER OR SUPPLIE	R	1709 F	ADDRESS, CITY, STATE, ZIP COD FARRAND AVE RTE, IN 46350	
	, INC SUMMARY (EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	1709 F	ARRAND AVE RTE, IN 46350  PROVIDER'S PLAN OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO T	DATE  COMPLETION DATE  are 219)  ass EO  9)  2-9446  any—(  nent of  sdh.in.g  /, (317)  ervices  377)  1  1  1  9)
				Department—(219) 326-686 12. La Porte County Emerg Management—(219) 898-11 13. State Emergency Management Agency—(317) 232-3980 14. Federal Emergency Management Agency—(312)	gency 491 7)

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D1VO21

Facility ID: 000849

9

If continuation sheet

Page 22 of 47

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/02/2018 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G331		A. BU	JILDING	<u></u>	COMPI	LETED	
		B. WI	NG		04/16	/2018	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEI	R			ARRAND AVE		
PALADIN	I, INC				RTE, IN 46350		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					408-5500		
					15. InTouch Pharmacy—(877	·)	
					464-7055		
					16. Primary Physician—Maur	een	
					Panares (219) 304-6100 and I	Vicki	
					Alexander (219) 878-5046		
					17. Dungarvin Indiana LLC (L		
					Porte County)—(326-6277) ar	nd	
					Opportunity Enterprise (Porter	•	
					County)—(219) 464-9621		
					If there is an emergency and s	staff	
					would need to get a hold of on	e of	
					the above and the phone is no	ot	
					working, staff will use their cel	l	
					phones as an alternate source	for	
					communication. Each DSM		
					(Direct Support Mentor) will ha	ave a	
					company cell phone to		
					communicate with emergency		
					officials and any other		
					administrative staff.		
					The method of choice for shar	-	
					medial documentation is throu	gh a	
					Participant Face Sheet. See		
					below:		
					PARTICIPANT FACE SHEET		
					Participant Name:		
					Admission Date:		
					Date of Birth:		
					ALLERGIES:		
					Medical Diagnosis:		
					Physician:		
					Current Medications:		
					MULICIA TO NICTIFICATION		
					WHOM TO NOTIFY WITH		
					EMERGENCIES AND		
	I		I		PROBLEMS		1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D1VO21 Facility ID: 000849

Contact Name

If continuation sheet

Page 23 of 47

PRINTED: 05/02/2018 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X		(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPL	ETED
		15G331		B. WING		04/16/2018	
		1.0000				0 11 101	
NAME OF P	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD		
					ARRAND AVE		
PALADIN	I, INC			LA POF	RTE, IN 46350		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DE CLUEDES EL LUCIDOS CONTROLIS		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	·	R LSC IDENTIFYING INFORMATION		TAG	TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
					Phone		
					Alt. Phone		
					Primary Representative/Conta	act	
					I minary representative/conte	101	
					Secondary Contact #1		
					Secondary Contact #1		
					Any restrictions on notificati	ion.	
					Any restrictions on notificati	ЮП.	
					MENTAL HEALTH STATUS		
					Cognitive or		
					Psychiatric/Behavioral		
					Disorders: (please list)		
					FUNCTIONAL STATUS		
					Ambulation		
					ز Independent		
					¿ Independent		
					Incontinent		
					Incontinent		
					Self-Feeding		
					Bathing		
					Other		
					Independent, Assisted:		
					Cana Walker Wheelebeir		
					Cane, Walker, Wheelchair		
					Urine		
					¿ Cupaniaian		
					Supervision .		
					¿ Cupaniaian		
					Supervision		
					i.		
					ن ا	<b>.</b>	
					¿ Confined to Bed or C	nair	
					Stool		
					ذ		
			1		Assisted		I

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D1VO21

Facility ID: 000849

If continuation sheet

Page 24 of 47

05/02/2018 PRINTED:

	OF HEALTH AND HU				FORM APPROVED OMB NO. 0938-039	
	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G331	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 04/16/2018	
	PROVIDER OR SUPPLIER	3	1709 F	ADDRESS, CITY, STATE, ZIP COD FARRAND AVE		
PALADIN	I, INC		LA PO	RTE, IN 46350		
(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)	(X5) COMPLETION DATE	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	Assisted  ¿ TREATMENT STATUS  ¿ Special Diet  ¿ Dysphagia  ¿ Mech Soft  ¿ Fluid restrictions  ¿ Infection  ¿ Contact precautions  ¿ Respiratory Precautions  Other special care needs:  Below is the document that wi used to provide information at the facility's needs and its abil to provide assistance to the authority have jurisdiction (locand State emergency management agencies, local a state public health department the Incident Command Center Emergency Operations Center designee). The occupancy of the state of the stat	II be bout ity all and its, the r, or	
				facility will affect its ability to	ine	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D1VO21

Facility ID: 000849

**Document** 

provide assistance.

**Occupancy and Assistance** 

If continuation sheet

Page 25 of 47

PRINTED: 05/02/2018 FORM APPROVED OMB NO. 0938-039

	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G331	(X2) MUL A. BUIL B. WING	DING	INSTRUCTION	(X3) DATE SURVEY COMPLETED 04/16/2018	
NAME OF F	PROVIDER OR SUPPLIE N, INC	R		1709 F <i>A</i>	ADDRESS, CITY, STATE, ZIP COD ARRAND AVE RTE, IN 46350		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
					Date: Facility Name: Location:		
					Type of Facility:		
					Maximum Census:  Occupancy Percentage:		
					# of Beds Occupied:		
					Needs of the Facility:	ļ	
					"None "Food "Water " Medical Supplies "Assistand with Evacuation and transfers		
E 0034							
Bldg	failed to ensure the communication pla providing informat occupancy, needs, assistance, to the a the Incident Commaccordance with 42	view and interview, the facility e emergency preparedness in includes a means of ition about the ICF/IID facility's and its ability to provide uthority having jurisdiction or nand Center, or designee in 2 CFR 483.475(c)(7). This could affect all occupants.	E 003	4	E-029 through E-035—Communication Plan Disasters can occur at any give time. All employees listed below ill be all hands on deck. A disaster requires the assistance all Group Home staff and administration. The President/CEO will assume responsibility for coordinating emergency actions. In case of absence, the Vice President of	ven  ow  ce of  f his	05/31/2018

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $D1VO21 \qquad {\it Facility ID:} \quad 000849$ 

If continuation sheet

Page 26 of 47

PRINTED: 05/02/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G331		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/16/2018	
NAME OF F	PROVIDER OR SUPPLIER		1709 F	ADDRESS, CITY, STATE, ZIP COD FARRAND AVE PRTE, IN 46350	
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	Based on record rev Supervisor on 04/16 p.m., the facility wa documentation for a including a means of the ICF/IID facility ability to provide as having jurisdiction of Center, or designed time of record revie	riew with the Maintenance 5/18 between 1:10 p.m. and 1:26		Participant Services will assuresponsibility. Appropriate information regarding the Emergency Preparedness Plawill be shared with clients and family during the Admission process and annually during conferences. Persons that wi involved in these emergency are as follows:  1. Bill  Trowbridge—President/CEO, Bill.Trowbridge@paladin.care (219) 510-3888.  2. Kimberly Latchford—Vio President of Participant Servi Kim.Latchford@paladin.care 898-5841.  3. Alanna Smith—Human Resource Manager, Alanna.Smith@paladin.care 646-4242  4. Kelsey Gant—Director of Residential Services, Kelsey.Gant@paladin.care, (309-5186.  5. Jeff Rupe—Program Manager, Jeff.Rupe@paladin (574) 305-1561.  6. James Mitchell—Direct Support Mentor, James.Mitchell@paladin.care 7. Jessica Jackson—Direct Support Mentor, Jessica.Jackson@paladin.care 9. Brittany Latchford—Direct Support Mentor, Tara.Payton@paladin.care 9. Brittany Latchford—Direct Support Mentor,	me an d case II be plans e ces, (219)  (708)  f 219)  .care

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D1VO21

Facility ID: 000849

If continuation sheet

Page 27 of 47

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/02/2018 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G331	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION :	X3) DATE SURVEY COMPLETED 04/16/2018
NAME OF P	ROVIDER OR SUPPLIE	ER	1709 F	ADDRESS, CITY, STATE, ZIP COD FARRAND AVE RTE, IN 46350	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	REGOLATORY			Brittany.Latchford@paladin.car 10. Ray Wolff—Direct Support Mentor, Ray.Wolff@paladin.ca 11. Curtis Jackson—Direct Support Mentor, Curtis.Jackson@paladin.care 12. Direct Support Staff (See Staff Roster) 13. Jimmy Kuta—Maintenance Supervisor, Jimmy.Kuta@paladin.care, (21 851-7844. 14. Shalanda Robinson—Corporate Complia Officer, Shalanda.Robinson@paladin.care (219) 688-1055. 15. Marjory Watson—Nursing Staff, Marjory.Watson@paladin.care (219) 362-2710 (7a-7p) or (219 608-1875. 16. Other Staff Designated as Needed by the President/CEO External Contacts: 1. EMERGENCY911 2. Fire Department—(219) 362-3456 3. Police Non-Emergency—(219) 362-94 4. Poison Control—(800) 222-1222 5. NIPSCO (gas leak emergency)—(800) 634-3524 6. Sentinel Alarm Company- 219) 874-6051 7. Indiana State Department Health (ISDH)—https://gatewayp.isdh.	e 99) nce care

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D1VO21

Facility ID: 000849

If continuation sheet

ov or incidents@isdh.in.gov, (317)

Page 28 of 47

PRINTED: 05/02/2018 FORM APPROVED OMB NO. 0938-039

CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039	
STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING			COMPLETED		
		15G331	B. W	ING		04/16	/2018	
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF I	PROVIDER OR SUPPLIEF	R			ARRAND AVE			
PALADIN	N, INC				RTE, IN 46350			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					233-1325			
					8. Indiana Bureau of			
					Developmental Disability Serv	ices		
					(BDDS)—			
					BQIS.Help@fssa.IN.gov, (877	)		
					218-3059			
					9. Indiana Protection and			
					Advocacy—(317) 722-5555			
					10. La Porte Hospital—(219)			
					326-1234			
					11. Local Health			
					Department—(219) 326-6808  12. La Porte County Emerger	2014		
					Management—(219) 898-149	•		
					13. State Emergency	ı		
					Management Agency—(317)			
					232-3980			
					14. Federal Emergency			
					Management Agency—(312) 408-5500			
					15. InTouch Pharmacy—(877	·)		
					464-7055			
					16. Primary Physician—Maure	een		
					Panares (219) 304-6100 and I	Vicki		
					Alexander (219) 878-5046			
					17. Dungarvin Indiana LLC (L			
					Porte County)—(326-6277) an			
					Opportunity Enterprise (Porter			
					County)—(219) 464-9621			
					If there is an emergency and s		1	
					would need to get a hold of on			
					the above and the phone is no			
					working, staff will use their cell			
					phones as an alternate source communication. Each DSM	: 101		
					(Direct Support Mentor) will ha	ave 2	1	
					company cell phone to	avea		
					communicate with emergency			
	I				I sommanioale with emergency		1	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D1VO21 Fa

Facility ID: 000849

officials and any other administrative staff.

If continuation sheet

Page 29 of 47

PRINTED: 05/02/2018 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER A.		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/16/2018	
NAME OF P	ROVIDER OR SUPPLIER	:	1709 F.	ADDRESS, CITY, STATE, ZIP COD ARRAND AVE RTE, IN 46350	
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				The method of choice for sha medial documentation is throu Participant Face Sheet. See below: PARTICIPANT FACE SHEET Participant Name: Admission Date: Date of Birth: ALLERGIES: Medical Diagnosis: Physician: Current Medications:	ring ugh a
				WHOM TO NOTIFY WITH EMERGENCIES AND PROBLEMS Contact Name Phone Alt. Phone Primary Representative/Contact	act
				Secondary Contact #1	
				Any restrictions on notificat  MENTAL HEALTH STATUS Cognitive or Psychiatric/Behavioral Disorders: (please list) FUNCTIONAL STATUS Ambulation ¿ Independent	ion:

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D1VO21 Facility ID: 000849

If continuation sheet

Page 30 of 47

PRINTED: 05/02/2018 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G331	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/16/2018
NAME OF P	ROVIDER OR SUPPLIER	R	1709 F	ADDRESS, CITY, STATE, ZIP COD ARRAND AVE RTE, IN 46350	
(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 APPROPRI- DEFICIENCY)	(X5) COMPLETION DATE
				Incontinent Self-Feeding Bathing Other Independent, Assisted:  ¿ Cane, Walker, Wheelchair Urine  ¿ Supervision  ¿ ¿ Confined to Bed or Ostool  ¿ Assisted  ¿ TREATMENT STATUS  ¿ Special Diet  ¿ Dysphagia  ¿ Mech Soft  ¿ Fluid restrictions  ¿ Infection  ¿ Contact precautions  ¿ Respiratory Precautions Other special care needs:	Chair

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D1VO21 Facility ID: 000849

If continuation sheet

Page 31 of 47

PRINTED: 05/02/2018 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G331	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/16/2018
NAME OF P	ROVIDER OR SUPPLIE	ER.	1709 F	ADDRESS, CITY, STATE, ZIP COD ARRAND AVE RTE, IN 46350	•
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N (X5) BE COMPLETION DATE
				Below is the document that used to provide information the facility's needs and its at to provide assistance to the authority have jurisdiction (I and State emergency management agencies, locastate public health department the Incident Command Center Emergency Operations Certesignee). The occupancy facility will affect its ability to provide assistance.  Occupancy and Assistance  Occupancy and Assistance  Document Date:  Facility Name:  Location:	about ability cocal al and ents, ater, the ater, or of the
				Type of Facility:	
				Maximum Census:	
				Occupancy Percentage:	
				# of Beds Occupied:	
				Needs of the Facility:	
				"None "Food "Water Medical Supplies "Assista with Evacuation and transfe	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D1VO21 Facility ID: 000849

If continuation sheet

Page 32 of 47

PRINTED: 05/02/2018 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G331	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION (X	3) DATE SURVEY COMPLETED 04/16/2018
NAME OF	PROVIDER OR SUPPLIE	R	1709 F	ADDRESS, CITY, STATE, ZIP COD FARRAND AVE RTE, IN 46350	
(X4) ID PREFIX TAG	(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0035					
Bldg	failed to ensure the communication plainformation from the facility has determined and their families of with 42 CFR 483.4 could affect all occurs and their families of with 42 CFR 483.4 could affect all occurs and the facility with the facility with the facility with documentation for includes a method the emergency plain determined is appropriate the time of record in the facility of the families or representation for the families or representation of the families of record in the families of th	view with the Maintenance 6/18 between 1:10 p.m. and 1:26 as unable to provide a communication plan which for sharing information from that the facility has opriate with clients and their intatives. Based on interview at review, the Maintenance and no documentation was	E 0035	E-029 through E-035—Communication Plan Disasters can occur at any giver time. All employees listed below will be all hands on deck. A disaster requires the assistance all Group Home staff and administration. The President/CEO will assume responsibility for coordinating emergency actions. In case of hi absence, the Vice President of Participant Services will assume responsibility. Appropriate information regarding the Emergency Preparedness Plan will be shared with clients and family during the Admission process and annually during cas conferences. Persons that will be involved in these emergency pla are as follows:  1. Bill Trowbridge—President/CEO, Bill.Trowbridge@paladin.care, (219) 510-3888. 2. Kimberly Latchford—Vice President of Participant Services Kim.Latchford@paladin.care (21898-5841. 3. Alanna Smith—Human Resource Manager, Alanna.Smith@paladin.care (70	of s e e e ns

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D1VO21

Facility ID: 000849

If continuation sheet

Page 33 of 47

PRINTED: 05/02/2018 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G331	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/16/2018
NAME OF PI	ROVIDER OR SUPPLIE	R	1709 F	ADDRESS, CITY, STATE, ZIP COD FARRAND AVE RTE, IN 46350	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
				646-4242 4. Kelsey Gant—Director Residential Services, Kelsey.Gant@paladin.care, 309-5186. 5. Jeff Rupe—Program Manager, Jeff.Rupe@paladi (574) 305-1561. 6. James Mitchell—Direct Support Mentor, James.Mitchell@paladin.car 7. Jessica Jackson—Direct Support Mentor, Jessica.Jackson@paladin.car 8. Tara Payton—Direct Sumentor, Tara.Payton@paladin.care 9. Brittany Latchford—Direct Support Mentor, Brittany.Latchford@paladin.care 10. Ray Wolff—Direct Supp Mentor, Ray.Wolff@paladin. 11. Curtis Jackson—Direct Support Mentor, Curtis.Jackson@paladin.car 12. Direct Support Staff (Se Staff Roster) 13. Jimmy Kuta—Maintenar Supervisor, Jimmy.Kuta@paladin.care, ( 851-7844. 14. Shalanda Robinson—Corporate Comp Officer, Shalanda.Robinson@paladin.car (219) 688-1055. 15. Marjory.Watson@paladin.car (219) 362-2710 (7a-7p) or (2	n.care  e ct are upport ect care ort care  e e nce (219)

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D1VO21 Facility ID: 000849

If continuation sheet Page 34 of 47

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/02/2018 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<del></del>	COMPLETED	
		15G331	B. WING	<u> </u>	04/16/2018	
NAME OF F	PROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP COD		
				ARRAND AVE		
PALADIN	I, INC		LA PO	RTE, IN 46350		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	1	(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		
				(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG		DATE	
				608-1875.		
				16. Other Staff Designated as		
				Needed by the President/CEC	)	
				External Contacts:		
				1. EMERGENCY911		
				2. Fire Department—(219)		
				362-3456		
				3. Police		
				Non-Emergency—(219) 362-9	9446	
				4. Poison Control—(800)		
				222-1222		
				5. NIPSCO (gas leak		
				emergency)—(800) 634-3524		
				6. Sentinel Alarm Company		
				219) 874-6051		
				1 · · · · · · · · · · · · · · · · · · ·	ut of	
				'	it oi	
				Health	- :	
				(ISDH)—https://gatewayp.isdh	-	
				ov or incidents@isdh.in.gov, (	317)	
				233-1325		
				8. Indiana Bureau of		
				Developmental Disability Serv	rices	
				(BDDS)—		
				BQIS.Help@fssa.IN.gov, (877	')	
				218-3059		
				9. Indiana Protection and		
				Advocacy—(317) 722-5555		
				10. La Porte Hospital—(219)		
				326-1234		
				11. Local Health		
				Department—(219) 326-6808		
				12. La Porte County Emerger	ncv	
				Management—(219) 898-149	-	
				13. State Emergency		
				Management Agency—(317)		
				232-3980		
				14. Federal Emergency		
				Management Agency—(312)		
				408-5500	l	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D1VO21 Facility ID: 000849

15. InTouch Pharmacy—(877)

If continuation sheet

Page 35 of 47

PRINTED: 05/02/2018 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  15G331	A. BUILDING B. WING		COM	E SURVEY PLETED 6/2018
NAME OF PE	ROVIDER OR SUPPLIEF	₹	1709 F	ADDRESS, CITY, STATE, ZIP C ARRAND AVE RTE, IN 46350	COD	
(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 S CROSS-REFERENCED TO THE / DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	464-7055 16. Primary Physician Panares (219) 304-616 Alexander (219) 878-517. Dungarvin Indiana Porte County)—(326-60 Opportunity Enterprises County)—(219) 464-96 If there is an emergene would need to get a hot the above and the phoworking, staff will use the phones as an alternate communication. Each (Direct Support Mentocompany cell phone to communicate with emergene with emergene with the above and the phoworking, staff will use the phones as an alternate communication. Each (Direct Support Mentocompany cell phone to communicate with emergene with emergene with the method of choice medial documentation Participant Face Sheet below:  PARTICIPANT FACE Participant Name: Admission Date: Date of Birth: ALLERGIES: Medical Diagnosis: Physician: Current Medications:  WHOM TO NOTIFY WEMERGENCIES AND	00 and Nicki 6046 a LLC (La 6277) and e (Porter 621 cy and staff old of one of one is not their cell e source for DSM r) will have a dergency for sharing is through a t. See  SHEET	DATE
				PROBLEMS Contact Name Phone Alt. Phone		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D1VO21 Facility ID: 000849

If continuation sheet

Page 36 of 47

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/02/2018 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDI	CAID SERVICES			OM	B NO. 0938-039
	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER  15G331	A. BUILDING B. WING	<del></del>	COMPLETED 04/16/2018	
		130331	<del></del>		04/10/	2016
NAME OF F	ROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP COD ARRAND AVE		
PALADIN	I, INC			RTE, IN 46350		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
				Primary Representative/Conta	ict	
				Secondary Contact #1		
				Any restrictions on notificati	on:	
				MENTAL HEALTH STATUS		
				Cognitive or		
				Psychiatric/Behavioral		
				Disorders: (please list)		
				FUNCTIONAL STATUS		
				Ambulation		
				¿ Independent		
				Incontinent		
				Self-Feeding		
				Bathing		
				Other		
				Independent, Assisted:		
				ن		
				Cane, Walker, Wheelchair		
				Urine .		
				¿ Supervision		
				•		
				¿ Supervision		
				¿		
				i		
				¿ Confined to Bed or C	hair	
				Stool		
				¿		
				Assisted		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D1VO21

Facility ID: 000849

Assisted

If continuation sheet

Page 37 of 47

PRINTED: 05/02/2018 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G331	UILDING	ONSTRUCTION	(X3) DATE COMPL <b>04/16</b> /	ETED
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD ARRAND AVE		
PALADIN	I, INC			RTE, IN 46350		
(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)	ATE	(X5) COMPLETION DATE
				TREATMENT STATUS  Special Diet  Dysphagia  Mech Soft  Fluid restrictions  Infection  Contact precautions  Respiratory Precautions Other special care needs:		
				Below is the document that we used to provide information at the facility's needs and its abit to provide assistance to the authority have jurisdiction (locand State emergency management agencies, local state public health department the Incident Command Cente Emergency Operations Cented designee). The occupancy of facility will affect its ability to provide assistance.  Occupancy and Assistance Document Date:	oout lity aal and ts, r, the er, or	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D1VO21

Facility ID: 000849

If continuation sheet

Page 38 of 47

PRINTED: 05/02/2018 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE	) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPL	ETED
		15G331	B. W	ING		04/16/	/2018
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER				ARRAND AVE		
DVIVDIV	LINC				RTE, IN 46350		
PALADIN	I, INC			LA POR	RTE, IN 46350		
(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	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Facility Name:		
					Location:		
					Type of Facility:		
					Maximum Census:		
					Occupancy Percentage:		
					# of Beds Occupied:		
					Needs of the Facility:		
					"None "Food "Water "		
					Medical Supplies "Assistance		
					with Evacuation and transfers		
E 0036							
D. I							
Bldg	D 1 1						0.7/24/2010
		riew and interview, the facility	E 0	036	E-036 through E-039—Trainii	ng	05/31/2018
	_	d maintain an emergency			and Testing Plan		
		ng and testing program that			The facility will create a progra		
		pdated at least annually in			that includes both initial training	•	
		CFR 483.475(d). This deficient			for new staff and recurring upo		
	practice could affec	t all occupants.			sessions for existing staff. The		
	Tr. 1				will be an annual refresher tra	•	
	Findings include:				mid-year during one of the mo		
		to the desired			staff meeting, for existing staff		
		view with the Maintenance			Drills will be conducted to inclu	ıde	
	_	6/18 between 1:10 p.m. and 1:26			mock disaster drills, which		
		preparedness training and			includes actual calls being ma	de	
	testing plan was ava	ailable for review. Based on	1		to emergency personnel.		l

FORM CMS-2567(02-99) Previous Versions Obsolete

interview at the time of record review, the

Event ID:

D1VO21

Facility ID: 000849

Annually the facility will conduct

If continuation sheet

Page 39 of 47

PRINTED: 05/02/2018 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G331	,	JILDING	ONSTRUCTION	(X3) DATE COMPL 04/16/	LETED
NAME OF I	PROVIDER OR SUPPLIE	R		1709 F	ADDRESS, CITY, STATE, ZIP COD ARRAND AVE RTE, IN 46350		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE.	(X5) COMPLETION DATE
E 0039	_	rvisor confirmed no such s available for review.			either one full-scale community exercise and one tabletop exercise, or two full-scale community exercises. All emergency preparedness test exercises and emergency ever will be documented.  The facility will maintain documentation of initial and an training for all staff. The documentation will include the specific training completed as as the methods used for demonstrating knowledge of the training program.  Plan will be introduced/implemented for orientation of the plan to staff month at all staff meeting.	ting ents nnual e well	
Bldg	failed to conduct e plan at least annua staff drills using th ICF/IID facility m participate in a full community-based exercise is not acce facility-based. If th an actual natural o requires activation ICF/IIC facility is community-based full-scale exercise the actual event; (i exercise that may in	view and interview, the facility exercises to test the emergency lly, including unannounced e emergency procedures. The last do all of the following: (i)scale exercise that is or when a community-based essible, an individual, lee ICF/IID facility experiences or man-made emergency that of the emergency plan, the exempt from engaging in a for individual, facility-based for 1 year following the onset of the conduct an additional include, but is not limited to the excend full-scale exercise that is	E 00	039	E-036 through E-039—Traini and Testing Plan The facility will create a prograthat includes both initial training for new staff and recurring upon sessions for existing staff. The will be an annual refresher trainid-year during one of the mostaff meeting, for existing staff. Drills will be conducted to inclumock disaster drills, which includes actual calls being matto emergency personnel.  Annually the facility will conductive one full-scale communities exercise and one tabletop exercise, or two full-scale	am ong date ere sining onthly f. ude	05/31/2018

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $D1VO21 \qquad {\it Facility ID:} \quad 000849$ 

If continuation sheet

Page 40 of 47

PRINTED: 05/02/2018 FORM APPROVED OMB NO. 0938-039

		IDENTIFICATION NUMBER  15G331	A. BUILDING B. WING		COMPLETED 04/16/2018
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD ARRAND AVE	
PALADIN	I, INC			RTE, IN 46350	
(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
	a tabletop exercise to discussion led by a foliocally-relevant e of problem statement prepared questions of emergency plan; (iii response to and main drills, tabletop exercised and revise the ICF/I as needed in accord (2). This deficient proccupants.  Findings include:  Based on record revision Supervisor on 04/16 p.m., no documentate community-based on interview at the total maintenance Supervisor on Sup	r individual, facility-based. (B) hat includes a group facilitator, using a narrated, mergency scenario, and a set hts, directed messages, or designed to challenge an ) analyze the ICF/IID facility's intain documentation of all bises, and emergency events, ID facility's emergency plan, lance with 42 CFR 483.475(d) ractice could affect all  iew with the Maintenance i/18 between 1:10 p.m. and 1:26 tion was available for either a r tabletop exercise drill. Based ime of record review, the visor confirmed that no drill available for review.		community exercises. All emergency preparedness testi exercises and emergency ever will be documented.  The facility will maintain documentation of initial and ar training for all staff. The documentation will include the specific training completed as as the methods used for demonstrating knowledge of the training program.  Staff will be tested for knowled and understanding of the plan exercises in the month of June all staff meeting.	nnts nnual well ne lge with
K 0000					'
Bldg. 01	conducted by the In- Health in accordance Survey Date: 04/16 Facility Number: 00 Provider Number: 1002 At this Life Safety C found not in complication	00849 15G331	K 0000		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D1VO21 Facility ID: 000849

If continuation sheet

Page 41 of 47

	of Correction identification number 15G331	A. BUILDING  B. WING	01	COMPLETED 04/16/2018
NAME OF F	PROVIDER OR SUPPLIER	1709 F	ADDRESS, CITY, STATE, ZIP COD ARRAND AVE RTE, IN 46350	
(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
	edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies.  This one story facility with a basement was not sprinklered. The facility has a monitored fire alarm system with smoke detection on all levels including in the corridors, in the living areas and in the client sleeping rooms. The facility has a capacity of 6 and had a census of 5 at the time of this survey.  Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 1.2.  Quality Review completed on 04/18/18 - DA			
K S200	NFPA 101			
Bldg. 01	Means of Egress Requirements - Other Means of Escape Requirements - Other 2012 EXISTING List in the REMARKS section any LSC Section 33.2.2 Means of Escape requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review and interview, the facility failed to maintain 2 of 2 battery operated emergency light in accordance with 33.1.1.3. LSC 33. 1.1.3 states the provisions of Chapter 4, General, shall apply. LSC 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall either be maintained or removed. LSC 7.9.3.1.1 testing of required emergency lighting systems shall be permitted to	K S200	K0200 On April 12, 2018, Approved F is scheduled to check the emergency lights as part of its annual inspection. In order to lup with inspections, the Corpo Compliance Officer has put in place a monthly inspection to lo	keep rate be

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $D1VO21 \qquad {\it Facility ID:} \quad 000849$ 

If continuation sheet

Page 42 of 47

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G331		ILDING	NSTRUCTION  01	(X3) DATE ( COMPL 04/16/	ETED
NAME OF E	PROVIDER OR SUPPLIEF			1709 FA	ADDRESS, CITY, STATE, ZIP COD ARRAND AVE RTE, IN 46350		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
IAU	be conducted as fol (1) Functional testin with a minimum of weeks between tests seconds.  (2) The test interval extended beyond 30 authority having jun (3) Functional testin for a minimum of 1 lighting is battery p (4) The emergency fully operational for (5) Written records shall be kept by the authority having jun This deficient pract the facility were recemergency during a 7.9.3, Periodic Test Equipment, requires conducted for 30 sean annual test to be battery powered em not less than a 1 ½ shall be fully operatest. Written record tests shall be kept by the authority having practice could affect.  Based on record rev Supervisor on 04/16 documentation for the emergency lights affective. Additionall operated emergency	lows:  Ing shall be conducted monthly,  3 weeks and a maximum of 5  Is, for not less than 30  Ishall be permitted to be  2 days with approval of the disdiction.  Ing shall be conducted annually  Ishours if the emergency owered.  Ilighting equipment shall be the duration of the test.  In of visual inspections and tests owner for inspection for the disdiction.  In could affect all occupants if the quired to evacuate in an the loss of normal power. LSC ing of Emergency Lighting is a functional test to be conds at 30 day intervals and conducted on every required the ergency lighting system for the conducted on the duration of the last of visual inspections and the sof visual inspections and the owner for inspection by the owner for inspection by the owner for inspection by the jurisdiction. This deficient		IAG	same day of every month. The report is printed out and filed we program Manager. DSMs and Program Manager be conducting random visits, a weekly reviews to ensure that maintenance is aware of any concerns and oversights in the inspections.	e vith will and	DATE
	011 01/12/17. Dased	on interview at the time of					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D1VO21 Facility ID: 000849

If continuation sheet

Page 43 of 47

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		15G331	B. W	ING	<del></del>	04/16/	/2018
				CTD FET A	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
	INC				ARRAND AVE		
PALADIN	, INC			LAPOR	RTE, IN 46350		
(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	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	observation, the Ma	intenance Supervisor					
	confirmed the testin	g was not performed.					
			İ				
K S345	NFPA 101						
	Fire Alarm System	n - Testing and					
Bldg. 01	Maintenance						
	Fire Alarm System	n - Testing and					
	Maintenance						
	2012 EXISTING (F	Prompt)					
	A fire alarm syster	n is tested and maintained					
	in accordance with	n an approved program					
	complying with the	e requirements of NFPA 70,					
	National Electric C	Code, and NFPA 72,					
	National Fire Alarr	n and Signaling Code.					
	Records of system	n acceptance, maintenance					
	and testing are rea	adily available.					
	9.7.5, 9.7.7, 9.7.8,	and NFPA 25					
	Based on record rev	riew and interview, the facility	KS	345	K0345		05/01/2018
	failed to ensure 1 of	1 fire alarm systems was			On April 12, 2018, Approve Fi	re is	
	maintained in accord	dance with 9.6.1.3. LSC 9.6.1.3			scheduled to check the sensiti	vity	
	requires a fire alarm	system to be installed, tested,			of the smoke detectors as part	of	
	and maintained in a	ccordance with NFPA 70,			its annual inspection. In order	to	
	National Electrical	Code and NFPA 72, National			keep up with inspections, the		
	Fire Alarm Code. N	NFPA 72, 7-3.2 requires testing			Corporate Compliance Officer	has	
	shall be performed i	n accordance with the Table			put in place a monthly inspecti	on	
	14.4.5 Testing Frequency	uencies. NFPA 72, 14.4.5.3.1			to be completed by Maintenan	ce	
	states sensitivity sha	all be checked within 1 year			on the same day of every mon	ıth.	
	after installation. NI	PFA 72, 14.4.5.3.2 states			The report is printed out and		
	sensitivity shall be o	checked every alternate year			filed with Program		
	thereafter unless oth	nerwise permitted by			Manager. DSMs and Program	1	
	compliance with 14	.4.5.3.3. This deficient practice			Manager will be conducting		
	could affect all occu	ipants.			random visits, and weekly revi	ews	
					to ensure that maintenance is		
	Findings include:				aware of any concerns and		
					oversights in the inspections.		
	Based on record rev	riew with the Maintenance					
	Supervisor on 04/16	5/18 between 1:10 p.m. and 1:26					
	p.m., no documenta	tion for a smoke detector					
	sensitivity test was a	available for review. Based on					
	•	e of record review, the					
			ı				I

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D1VO21 Facility ID: 000849

If continuation sheet Page 44 of 47

STATEME	NT OF DEFICIENCIES  OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G331	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	X3) DATE SURVEY COMPLETED 04/16/2018
NAME OF	PROVIDER OR SUPPLIEI N, INC	2	1709 F	ADDRESS, CITY, STATE, ZIP COD ARRAND AVE RTE, IN 46350	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY O	STATEMENT OF DEFICIENCIE SCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION EVISOR acknowledged the	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	aforementioned con	ndition and confirmed no other available for review.			
K S712 Bldg. 01	least quarterly for under varied conda. Ensure that a trained to perform b. Ensure that a familiar with the under emergency and disprocedures.  2. The facility must a. Actually evactioned in the condition of clied disabilities;  c. File a report and disabilities;  c. File a report and disabilities;  d. Investigate and drills, including and action; and  e. During fire drevacuated to a safe under the Health of the Life Safety  3. Facilities must paragraphs (i) (1)	all personnel on all shifts are assigned tasks; all personnel on all shifts are se of the facility's isaster plans and st: auate clients during at least or on each shift; provisions for the ants with physical and evaluation on each drill; and evaluation excidents and take corrective sills, clients may be after area in facilities certified Care Occupancies Chapter Code.  The meet the requirements of and (2) of this section for a staff that they utilize.			
	Based on record facility failed to co of 4 quarters. LSC conducted quarterly	review and interview, the nduct quarterly fire drills for 1 19.7.1.6 requires drills to be on each shift under varied ficient practice affects all staff	K S712	K712 Fire drills will be conducted a least quarterly for each shift. Staff have been trained on ho the drills should be conducte	w

FORM CMS-2567(02-99) Previous Versions Obsolete

and clients.

Event ID:

D1VO21

Facility ID: 000849

and recorded. Staff will be

If continuation sheet

Page 45 of 47

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	î í		ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<u>01</u>	COMPLETED
		15G331	B. W	ING		04/16/2018
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD ARRAND AVE	
PALADIN	I, INC				RTE, IN 46350	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION		TAG		DATE
	E. 1 1 1				sure to have individuals	
	Findings include:				evacuated and report how th	ie
	Based on record rev	view of the "Post Drill/ Test of			drill was complete with and concerns or suggestions	
	Emergency Procedures" forms with the Maintenance Supervisor on 04/16/18 at 10:52 a.m.,				needed. Program Manager	
					has established a schedule f	or
		nentation for a second shift fire			all homes to be sure that the	
		rter of 2018. Based on interview			fire drills are random and in	
		l review, the Maintenance			accordance of the	
		ble to provide further			requirements.	
	documentation.					
					Fire drill forms will be update	ted
	3.1-19(b) 3.1-51(c)				to be sure that alternative	
					routes or 2nd egress were	
					attempted and trained on.	
		review and interview, the			Care Coordinator/Program	
	1	sure 5 of 5 clients utilized all			Manager will provide training	
	_	lls and were able to choose an			to staff as well as individuals	5
		he primary exit were blocked.			learn and practice alternate	
	_	res resident training to include			routes if escape is blocked.	
		if the primary escape route is			EX: windows- how to operat	
		3.3 requires that drills shall			and signal for help- not actu	-
		vacuation of all clients to an specified in the emergency			practicing evacuation thru to window.	ie
		ide clients with experience in			willdow.	
		ll exits and means of escape			Use of calendars and	
		de. LSC 33.7.3.5 Actual exiting			reminders with	
		not be required to comply			emails/notifications will limit	
		g the window and signaling for			any missed drills. DSMs and	
		eptable alternative. Finally,			Care Coordinator will be	
	_	res exits and means of escape			reviewing fire drills being	
	not used in any drill	shall not be credited in			complete on weekly visits ar	nd
	meeting the require	ments of this Code for board			use of the mock survey to	
	and care facilities.	This deficient practice affects			report how they did. This wi	II
	all occupants.				be shared monthly at all staf	f
					meetings. Program manage	
	Findings include:				will then be sure that all drill	
	_				are completed, reported and	
		view of the "Post Drill/ Test of			filed.	
	Emergency Procedu	ires" form with the				I

PRINTED: 05/02/2018 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G331	ĺ	ILDING	onstruction 01	(X3) DATE COMPL <b>04/16</b> /	ETED
NAME OF P	PROVIDER OR SUPPLIER			1709 F	ADDRESS, CITY, STATE, ZIP COD ARRAND AVE RTE, IN 46350		
(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)	ΓE	(X5) COMPLETION DATE
	none of the last twe secondary egress we nonsprinklered hom time of record revie acknowledged there available to demons	visor on 04/16/18 at 1:15 p.m., live fire drills indicated as practiced in the lee. Based on interview at the w, the Maintenance Supervisor was no other documentation trate secondary egress was le drills within the past year.					

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: D1VO21 Facility ID: 000849 If continuation sheet Page 47 of 47