STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G045	A. BUILDING 00 B. WING	03/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALADIN, INC	829 EARL RD MICHIGAN CITY, IN 46360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for the investigation of complaint #IN00346465. Complaint #IN00346465: Substantiated, Federal and state deficiencies related to the allegation are cited at W154 and W157. Unrelated deficiencies cited. Dates of Survey: March 11, 12 and 15, 2021. Facility Number: 000601 Provider Number: 15G045 Aims Number: 100233480 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 3/30/21.	W 0000		
W 0153 Bldg. 00	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 1 of 9 allegations of abuse and neglect reviewed, the facility failed to report 1 allegation of neglect of clients A, B, C, D, E, and F to the appropriate state authority within 24 hours of the time of knowledge in accordance with state law. Findings include:	W 0153	**W153-** To correct this deficiency now and in the future for the involved individuals and those that possibly could have been affected, Paladin will ensure that all allegations of mistreatment, neglect or abuse as well as unknown injuries are reported immediately and within	04/09/2021

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) reports and related investigations were reviewed on 3/11/21 at 11:33 am. A BDDS report dated 2/3/21 indicated the following: Date of Incident: 1/29/21 Date of Knowledge: 2/1/21 Submitted Date: 2/3/21 "On 2/1/21, it was brought to out (sic) attention by staff that another staff member was sleeping on the job and not attentive to the individuals needs. This was brought to Program Manager's attention on 2/1 in regards to the shift of 1/29. [Staff #1] came into work at 1 pm and laid on the couch with mask pulled over eyes/face and was sleeping for approximately 20 minutes. Staff asked her to get up to assist with individuals' needs, and it was ignored, and she continued to lay on the couch with mask on face until a shift change of staff around 3 pm. On 2/1, once this was reported, an investigation was started by the assistant director (AD #1) and HR (human resources). Staff was suspended, interviews were conducted with staff present and that have worked with [staff #1] that day/week. Individuals were also interviewed along with [staff #1]. After a thorough investigation and admission from [staff #1] of 'nodding' off during her shift, [staff #1] was terminated for policy violations and neglectful supervision of individuals that require 24 hours of supervisory care.		state guidelines. This state regulation and Paladin policy has been reviewed and trained to all staff upon hire and again periodically – the last retraining of policies was at an all staff training where this was reviewed was 2/25 and then again at separate house meetings on 3/23 and 3/24. Any staff that miss meetings will meet 1:1 with managers to get this information and training. Program manager have sent out quizzes of competency on 4/5 to have returned on 4/9. These will be reviewed at next all staff meeting again on 4/22. An email with attached policies will be sent out by the Director on 4/7 to again reemphasize the importance of the following all regulations and policies. For the staff that didn't report timely, she was held accountable in accordance to Paladin performance improvement policies. IDT members will randomly visit weekly to sites to ensure these policies are being followed and reported as needed. Signs are also posted in all sites when to report all MANE.	

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	All individuals were unharmed and cared for during this time with another staff member present." AD #1 was interviewed on 3/11/21 at 12:22 pm and stated, "All allegations are reported to BDDS within 24 hours of knowledge." 9-3-2(a)			
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 record review and interview for 4 of 23 allegations of abuse and neglect reviewed, the facility failed to conduct thorough investigations of 2 incidents of elopement requiring police intervention for client A, 1 fall with injury for client A, and 1 incident of peer to peer aggression for clients A and B. Findings include. The facility's Bureau of Developmental Disabilities Services (BDDS) reports and related investigations were reviewed on 3/11/21 at 11:33 am. 1. A BDDS report dated 12/9/20 indicated the following: "[Client A] fell onto concrete and hit her head. Plan to Resolve (Immediate and Long Term). [Client A] was transported by ambulance to [name of hospital], treated, and released." A follow up dated 12/15/20 indicated the following:	W 0154	**W154-** To correct this deficiency now and in the future for the individuals involved or could have been affected, Paladin has updated their investigation forms and process to ensure that all investigations are thorough. (SEE ATTACHED) This form has included all the listed incidents (elopement/falls/peer to peer aggression) to be investigated by the program manager- this investigation includes interviews with all staff and individuals involved. After the interviews, the process must be to review plans to see if they were followed, working or to be revised. The form was updated to have a section for this as well as Program Manager trained to ensure that all plans/goals are reviewed or updated as needed. Once this is	04/09/2021

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	"PM (Program Manager) #1 spoke with [client A] who reported she does not remember what happened or why she fell, only that she fell while sitting in a chair on the porch of the home. [PM #1] spoke with staff on duty. Staff were consistent with their report. Staff spoke with able consumers in the home. Consumers report they did not see the fall but confirmed statements of staff. [Client A] was outside on the front porch, sitting in a chair. No person observed the event. [Client A] was alone and being monitored by staff. Staff looked away for a moment and consumer reported [client A] had fallen. Staff immediately went to the aid of [client A] who was on the ground with a chair tipped over to the left. [Client A] was bleeding from her left forehead. 911 was called, and [client A] was transported by ambulance to the hospital where she was examined and treated for her head injury and released. [Client A] reported her arm was 'hurting.' This was also evaluated. [Client A's] abrasion on her left forehead was treated with OTC (over the counter) topical ointment in an effort to prevent infection and promote healing. [PM #1] observed the injury. There was no bruising, redness, or swelling. [Client A's] injury was observed to be healing." - The review did not indicate an investigation was conducted. 2. A BDDS report dated 1/9/21 indicated the following: "[Client A] commented to housemate [client B] that began a verbal argument. [Client A] walked outside to distance herself from [client B]. [Client A] was followed outside by [client B] who continued to yell at [client A]. Staff redirected consumers into the home and processed with them together and individually. [Client A] and [client B] began yelling at each other again.		established, corrective actions will be put in place immediately to ensure safety of individuals and training/ disciplinary actions for staff. These investigations will be completed timely to be reviewed by the director to ensure if any further actions are needed. These are then sent to Compliance Officer to file and reviewed monthly by the Compliance committee. Director will For some of the specific incidents – Clients- BSPs/ risk plans were reviewed and updated due to missing items. These were trained with staff at the house meeting on 3/23. IDT will review monthly and ensure that any revisions or updates have been completed and staff trained as these are changed.	

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	[Client B] invaded [client A's] personal space, yelling in [client A's] face. Staff attempted to intervene. [Client A] and [client B] pushed staff away. [Client A] pushed [client B]. [Client B] used closed fist to repeatedly hit [client A]. [Client A] used closed fists to repeatedly hit [client B]. [Client B] pulled [client A] down to the ground by her hair and let go. [Client A] got up. Staff processed with both [client A] and [client B]. [Client A] reported she was bleeding from the altercation, but no blood was visible. [Client B] had a scratch on her left cheek, approximately one and half inches long from [client A's] nail." - An investigation dated 1/8/21 did not indicate a review of clients A and B's Behavior Support Plans (BSPs) or staff actions and did not indicate corrective actions to be taken. 3. A BDDS report dated 1/9/21 indicated the following: "On 1/8/21 at approximately 6:30 pm, [client A] left the residence while staff was preoccupied working with another consumer. [Client A] was out of site (sic) for approximately 30 minutes. [Client A] went to neighbor's home, called 911, and was transported to [name of hospital] by ambulance where she remained under the supervision of medical professions (sic) until picked up by [Qualified Intellectual Disabilities Professional (QIDP) #1] at approximately 7:00 pm." - An investigation dated 1/9/21 did not indicate a review of client A's BSP or staff actions and did not indicate corrective actions to be taken. 4. A BDDS report dated 1/27/21 indicated the following:			

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	"On 1/26/21 at approximately 7:05 pm, [client A] eloped from her residence in SGL (supported group living). [Client A] was out of site (sic) of staff for approximately 30 minutes. Staff called law enforcement for assistance. Staff was unable to locate [client A] by vehicle. [Client A] was with law enforcement within 10-15 minutes of leaving the residence." - An investigation dated 1/26/21 did not indicate a review of client A's BSP or staff actions and did not indicate corrective actions to be taken. Assistant Director (AD) #1 was interviewed on 3/11/21 at 12:22 pm and stated, "The investigation includes a review of the BSP. The person conducting the investigation should review the plan and interview staff to determine if the plan was implemented correctly or needs to be revised." This federal tag relates to complaint #IN00346465. 9-3-2(a)			
W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 6 of 23 allegations of abuse and neglect reviewed, the facility failed to implement effective corrective measures for client A. Findings include: The facility's Bureau of Developmental Disabilities Services (BDDS) reports and related investigations were reviewed on 3/11/21 at 11:33 am.	W 0157	**W157-** To correct the deficiency now and in the future for the individual involved or could have been involved, Paladin will ensure appropriate corrective action is taken. After using the Investigation form for investigating the incident it should now be determined the corrective action needed to ensure safety.	04/09/2021

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	1. A BDDS report dated 12/9/20 indicated the following: "[Client A] fell onto concrete and hit her head. Plan to Resolve (Immediate and Long Term). [Client A] was transported by ambulance to [name of hospital], treated, and released." A follow up dated 12/15/20 indicated the following: "PM (Program Manager) #1 spoke with [client A] who reported she does not remember what happened or why she fell, only that she fell while sitting in a chair on the porch of the home. [PM #1] spoke with staff on duty. Staff were consistent with their report. Staff spoke with able consumers in the home. Consumers report they did not see the fall but confirmed statements of staff. [Client A] was outside on the front porch, sitting in a chair. No person observed the event. [Client A] was alone and being monitored by staff. Staff looked away for a moment and consumer reported [client A] had fallen. Staff immediately went to the aid of [client A] who was on the ground with a chair tipped over to the left. [Client A] was bleeding from her left forehead. 911 was called, and [client A] was transported by ambulance to the hospital where she was examined and treated for her head injury and released. [Client A] reported her arm was 'hurting.' This was also evaluated. [Client A's] abrasion on her left forehead was treated with OTC (over the counter) topical ointment in an effort to prevent infection and promote healing. [PM #1] observed the injury. There was no bruising, redness, or swelling. [Client A's] injury was observed to be healing." - The review did not indicate an investigation was conducted. - The review did not indicate a high risk plan		This will be indicated on the report by the Program Manager. We will review to see if action taken worked, an isolated incident, revisions with updates or if something needs created. If revisions are needed, it could specify the updates, training, disciplinary actions and who will be responsible for completing this. For some of the specific citations for this survey, BSPs were reviewed with IDT, risk plans(elopement/falls) updated and filed, adaptive equipment was ordered and back up equipment purchased. These items will continue to be reviewed and assessed with any incident in future by the IDT monthly meetings. IDT will ensure they are being followed and available in the sites with weekly visits. Compliance committee assists in another review bi-monthly to have the investigations completed and corrective actions are completed timely.	

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	addressing client A's falls. 2. A BDDS report dated 1/9/21 indicated the following: "[Client A] commented to housemate [client B] that began a verbal argument. [Client A] walked outside to distance herself from [client B]. [Client A] was followed outside by [client B] who continued to yell at [client A]. Staff redirected consumers into the home and processed with them together and individually. [Client A] and [client B] began yelling at each other again. [Client B] invaded [client A's] personal space, yelling in [client A's] face. Staff attempted to intervene. [Client A] and [client B] pushed staff away. [Client A] pushed [client B]. [Client B] used closed fist to repeatedly hit [client A]. [Client A] used closed fists to repeatedly hit [client B]. [Client B] pulled [client A] down to the ground by her hair and let go. [Client A] got up. Staff processed with both [client A] and [client B]. [Client A] reported she was bleeding from the altercation, but no blood was visible. [Client B] had a scratch on her left cheek, approximately one and half inches long from [client A's] nail." - An investigation dated 1/8/21 did not indicate a review of clients A and B's Behavior Support Plans (BSPs) or staff actions and did not indicate corrective actions to be taken. 3. A BDDS report dated 1/9/21 indicated the following: "On 1/8/21 at approximately 6:30 pm, [client A] left the residence while staff was preoccupied working with another consumer. [Client A] was out of site (sic) for approximately 30 minutes. [Client A] went to neighbor's home, called 911,			

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	and was transported to [name of hospital] by ambulance where she remained under the supervision of medical professions (sic) until picked up by [Qualified Intellectual Disabilities Professional (QIDP) #1] at approximately 7:00 pm." - An investigation dated 1/9/21 did not indicate a review of client A's BSP or staff actions and did not indicate corrective actions to be taken. 4. A BDDS report dated 1/23/21 indicated the following: "[Client A] was sitting on the side of her bed, utilizing her tablet, when she fell asleep and slid off of her bed. [Client A] reported her right leg rubbed against metal of frame (sic) when she slid, and the right side of her head hit her wooden footboard (blunt not sharp). [Client A] obtained injuries to her outer, upper thigh and the right side of her forehead. Injuries are consistent with report. Injury to her right leg is approximately 3-3 1/2 inches in length and approximately 1 inch wide. Injury on leg is consistent with a deep rubbing. Injury to right forehead is approximately 1 inch in diameter, appears red with minor scrapping (sic). [Client A] reported she is not in pain." - The review did not indicate a high risk plan to address client A's falls. 5. A BDDS report dated 1/27/21 indicated the following: "On 1/26/21 at approximately 7:05 pm, [client A] eloped from her residence in SGL (supported group living). [Client A] was out of site (sic) of staff for approximately 30 minutes. Staff called law enforcement for assistance. Staff was unable to locate [client A] by vehicle. [Client A] was with law enforcement within 10-15 minutes of leaving the residence."			

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	- An investigation dated 1/26/21 did not indicate a review of client A's BSP or staff actions and did not indicate corrective actions to be taken. 6. A BDDS report dated 2/20/21 indicated the following: "On 2/20/21 at approximately 12:30 am, [client A] reported she attempted to get out of bed when she was 'shaky.' [Client A] reported she was getting up out of her bed, she fell onto the smooth linoleum flooring, hitting her head on the flooring. [Client A] was observed to have a circular injury on her right forehead, in her hairline. The injury is consistent with the report." - The review did not include a high risk plan addressing client A's falls. Assistant Director (AD) #1 was interviewed on 3/11/21 at 12:22 pm and stated, "The investigation includes a review of the BSP. The person conducting the investigation should review the plan and interview staff to determine if the plan was implemented correctly or needs to be revised." AD #1 stated, "The person doing the investigation should make sure we have a plan in place and everyone is aware of it. They should determine who needs to be trained and what should be done in the future." This federal tag relates to complaint #IN00346465. 9-3-2(a)			
W 0227 Bldg. 00	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the			

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	comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review, and interview for 1 of 3 sampled clients (A), the facility failed to develop plans to address client A's falls, self-injurious behaviors (SIBs), and refusal to wear her helmet. Findings include: Observations were conducted at the group home on 3/11/21 from 3:30 pm through 5:00 pm. Client A was present in the group home and was not wearing her protective helmet for the duration of the observation period. Staff did not provide prompts for client A to wear her protective helmet. At 3:30 pm, client A arrived to the home with Direct Support Professional (DSP) #1. DSP #1 indicated she had taken client A to an appointment. Client A had a discolored scab in the center of her forehead at her hairline measuring 2 inches wide and 1 inch high. At 3:40 pm in client A's bedroom, there was a pink protective helmet on a shelf. Client A indicated the helmet was too small. DSP #2 was interviewed on 3/11/21 at 3:48 pm. DSP #2 indicated a box on a shelf in the medication room and stated, "She has a helmet in her room, but it's tight. She has a new one in the office, but we have to get it resized. Anytime she goes on an outing with staff, she's supposed to wear the helmet." DSP #2 stated, "[Client A] has SIBs. She'll try to do a power struggle. She'll tell staff, 'Do this, or I'll have a behavior and hurt	W 0227	**W227-** To correct this deficiency now and in the future for the individual affected and who could have possibly been affected, Paladin has used the Comprehensive Functional Assessments to update ISPs for best practices to be successful as well as maintain safety. Program managers will develop goals to be added to encourage and support the use of adaptive equipment (Helmet) when refusals have jeopardized individual's safety and reduce the incidents of SIB. These goals will be used by staff to promote safety and independence. Strategies will be given to staff to promote the most successful outcomes. They will document on the goals success rate and the data will be used for assisting in the team on revising plans and better assisting the individuals. The data will also be sent to the doctors who are prescribing medications and seeing the individuals for counseling for record on how it is working or needing to be revised/updated. For the specific case, client A has started weekly counseling visits to assist in her overall mental health which will tie into the decrease in SIB/ falls and wearing her helmet. The goals will be analyzed monthly	04/09/2021

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	myself.'" DSP #2 stated, "[Client A] does fall a lot. We keep our eyes on her when she's agitated. She falls out of bed, so she has bed rails. She pretends to have seizures and slides down the end of the bed and hurts herself. She fell on [3/6/21] and hit her head on the concrete." Client A was interviewed on 3/11/21 at 3:40 pm. Client A stated, "I have mild seizures and fall out of bed. I have a helmet, but it doesn't fit. It's in the office." Client A indicated she did not want to talk about her elopement, falls, or seizures any further. DSP #3 was interviewed on 3/11/21 at 4:10 pm and stated, "[Client A] is allowed to sit on the front porch when she's upset. It helps her calm down. We open the blinds, so we can see her. When she's outside, she has to be visible from the window at all times. Staff should be watching her constantly." DSP #3 stated, "[Client A] is supposed to wear the helmet all the time. She won't when she's at home. The one in her bedroom was too snug. We're waiting on a new one to come in." Client A's record was reviewed on 3/11/21 at 1:30 pm. Client A's Behavior Support Plan (BSP) dated 10/2020 did not indicate a plan to address client A's SIBs. Client A's record did not include a high risk plan to address client A's falls. Client A's record did not include a plan to address client A's refusal to wear her protective helmet.		by the program managers to see the progress of goals to see if any revisions will be needed. IDT weekly visits will also be reviewed to ensure the accuracy of the staff performing the goals regularly. All staff meetings are held monthly, to ensure the best potential of success for communication and knowledge of updates.	

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	15G045	A. BUILDING 00 B. WING	03/15/2021

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	Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed by phone on 3/15/21 at 9:55 am and stated, "[Client A] does engage in SIBs. Her BSP should address it." QIDP #1 stated, "[Client A] has a history of falling. The nurse does an evaluation for falls annually. She should have a risk plan addressing the falls." QIDP #1 stated, "There's no written plan addressing [client A's] refusal to wear the helmet. There should be a plan." Assistant Director (AD) #1 was interviewed by phone on 3/15/21 at 10:28 am and stated, "[Client A's] BSP should address her SIBs." AD #1 stated, "[Client A] should have a risk plan to address her falls." AD #1 stated, "There's not a program for staff to implement to train [client A] to wear her helmet more often. We should have that in place." 9-3-4(a)			
W 0264 Bldg. 00	483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. Based on record review and interview for 1 of 3 sampled clients (A), the facility failed to ensure interventions used to manage client A's behaviors had HRC (Human Rights Committee) approval. Findings include:	W 0264	**W264-** To correct this deficiency now and for the future of individuals affected and who could have been affected Paladin has ensured that all protection of client rights have been reviewed and approved by	04/09/2021

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	The facility's Bureau of Developmental Disabilities Services (BDDS) reports and investigations were reviewed on 3/11/21 at 11:33 am. An investigation dated 2/20/21 indicated the following: "[Client A] will be provided with video monitoring while in her room, in an effort to assist [client A] with preventing injuries and SIB (self-injurious behaviors), until [client A] demonstrates her ability to effectively communicate her needs to staff in an effort to prevent injuries. The video will be a monitor and not a recording. The monitor will be positioned to view [client A] in bed. The monitor will only be used when [client A] is in bed for the night." Client A's record was reviewed on 3/11/21 at 1:30 pm. Client A's record did not include HRC approval for the use of monitors in her bedroom. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed by phone on 3/15/21 at 9:55 am and stated, "There is a monitor in [client A's] bedroom. The monitor is not in her current BSP (Behavior Support Plan). I don't believe we have HRC approval for the monitor. It was discussed with the IDT (Interdisciplinary Team) and the guardian." Assistant Director (AD) #1 was interviewed by phone on 3/15/21 at 10:28 am and stated, "The monitor has been put in place. We talked with the guardian. The monitor should be in her plan, and it should have HRC approval."		the guardian and HRC. This practice has been done for other individuals and Paladin is aware of the regulation. Guardian is aware of the use of a monitor system within the individual's room that does impose on privacy but has also assisted in client safety. The plan has been developed to assist with the safety of individuals. HRC was contacted but was not able to meet with restrictions of COVID. Emails for approval were also sent out and were not followed up with at the time. This process has been followed up with again with phone calls and emails to ensure we have on file the approvals for the use of the monitor to ensure safety of falls and SIB. Plans will be updated and retrained to ensure all staff are following the proper use for maximum protection. Team Leads and IDT members will be sure to check on the staff that these plans are followed consistently while in the homes weekly.	

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W 0289 Bldg. 00	9-3-4(a) 483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. Based on record review and interview for 1 of 3 sample clients (A), the facility failed to ensure interventions used to manage client A's behaviors were written in her ISP (Individual Support Plan) and BSP (Behavioral Support Plan). Findings include: The facility's Bureau of Developmental Disabilities Services (BDDS) reports and investigations were reviewed on 3/11/21 at 11:33 am. An investigation dated 2/20/21 indicated the following: "[Client A] will be provided with video monitoring, while in her room, in an effort to assist [client A] with preventing injuries and SIB (self-injurious behaviors), until [client A] demonstrates her ability to effectively communicate her needs to staff in an effort to prevent injuries. The video will be a monitor and not a recording. The monitor will be positioned to view [client A] in bed. The monitor will only be used when [client A] is in bed for the night." Client A's record was reviewed on 3/11/21 at 1:30 pm. Client A's BSP dated 10/2020 did not include the	W 0289	**W289-** To correct this deficiency now and for the future of individuals affected and who potentially could have been affected Paladin will use systematic interventions to manage behaviors that are implemented into the ISP. Goals will be written in ISPs to match any target behaviors to assist in decreasing the unwanted behaviors. These goals will be measureable goals that staff can run and record the data for the team, counselor and physicians to review to help support the individuals. These goals will be analyzed monthly for progress and updated as needed. For the individual indicated in survey, BSP has been updated for new target behaviors(SIB), ISP has been updated with new goals, and individual medications have been reviewed with team for any adjustments with follow ups every 3 months and counseling weekly. All adjustments to plans have been reviewed and trained to staff at	04/09/2021

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	use of monitors in client A's bedroom or approval by the Human Rights Committee (HRC). Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed by phone on 3/15/21 at 9:55 am and stated, "There is a monitor in [client A's] bedroom. The monitor is not in her current BSP. I don't believe we have HRC approval for the monitor. It was discussed with the IDT (Interdisciplinary Team) and the guardian." Assistant Director (AD) #1 was interviewed by phone on 3/15/21 at 10:28 am and stated, "The monitor has been put in place. We talked with the guardian. The monitor should be in her plan, and it should have HRC approval." 9-3-5(a)		house meetings. HRC has been sent any new restrictive measures for approval and revisions to BSPs. IDT will continue to monitor with random weekly visits and running behavior reports to see the progress in goals and incidents/investigations.	
W 0436 Bldg. 00	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review, and interview for 1 of 3 sampled clients (A), the facility failed to ensure client A had a properly fitting protective helmet available for her use. Findings include: Observations were conducted at the group home on 3/11/21 from 3:30 pm through 5:00 pm.	W 0436	**W436** To correct this deficiency now and for the future of individuals affected and who potentially could have been affected Paladin, will ensure all adaptive equipment is available, in good repair and teach individuals to be informed to make choices to wear in accordance to plans and goals.	04/14/2021

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	Client A was present in the group home and was not wearing her protective helmet for the duration of the observation period. Staff did not provide prompts for client A to wear her protective helmet. At 3:30 pm, client A arrived to the home with Direct Support Professional (DSP) #1. DSP #1 indicated she had taken client A to an appointment. Client A had a discolored scab in the center of her forehead at her hairline measuring 2 inches wide and 1 inch high. At 3:40 pm in client A's bedroom, there was a pink protective helmet on a shelf. Client A indicated the helmet was too small. DSP #2 was interviewed on 3/11/21 at 3:48 pm. DSP #2 indicated a box on a shelf in the medication room and stated, "She has a helmet in her room, but it's tight. She has a new one in the office, but we have to get it resized. Anytime she goes on an outing with staff, she's supposed to wear the helmet." Client A was interviewed on 3/11/21 at 3:40 pm. Client A stated, "I have mild seizures and fall out of bed. I have a helmet, but it doesn't fit. It's in the office." DSP #3 was interviewed on 3/11/21 at 4:10 pm and stated, DSP #3 stated, "[Client A] is supposed to wear the helmet all the time. She won't when she's at home. The one in her bedroom was too snug. We're waiting on a new one to come in." Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed by phone on 3/15/21		The helmet was available but not properly fitting. Nurse has ordered foam to be placed on the inside of helmet as the individual likes the helmet she had. In case this foam would be taken out, Paladin has purchased another for a backup that the individual agreed to wear for back up. Her helmet will be worn as ordered and reviewed each morning by staff to ensure it is in good repair. Staff will document on her goals and the eMAR to indicate use of or any refusals daily. IDT will review any incidents of refusals and patterns of success to better revise plan to ensure safety. Program manager will make adjustments to plans as needed.	

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	at 9:55 am and stated, "The original helmet, she said she wouldn't wear because it was too small. It hurt her ears and squeezed her head. We had her fitted for a new helmet, but it's too big and covers her eyes. We're discussing what can be done. They both work. She can use them, but she's not likely to wear them because they aren't comfortable." Assistant Director #1 was interviewed by phone on 3/15/21 at 10:28 am and stated, "We need to have a properly fitting helmet." 9-3-7(a)			