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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G171 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 08/02/2013 |
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| NAME OF PROVIDER OR SUPPLIER TRADEWINDS SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 220 E GREENWOOD CROWN POINT, IN 46307 |
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| W000000 | <p>This visit was for an extended annual recertification and state licensure survey.</p> <p>Dates of survey: July 19, 22, 23, 24, 25, 26 and August 2, 2013.</p> <p>Facility number: 000705 Provider number: 15G171 AIM number: 100248690</p> <p>Surveyor: Christine Colon, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 8/20/13 by Ruth Shackelford, QIDP.</p> | W000000 | | |

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| W000122 | <p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, record review and interview, the Condition of Participation: Client Protections, is not met as the facility failed to protect 3 of 4 sampled clients and 1 additional client (clients #1, #2, #4 and #7) from physical aggression, failed to have written documentation to indicate thorough investigations were completed and failed to take sufficient corrective action to prevent recurrence of incidents.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Please refer to W149. The facility failed to implement their abuse/neglect policy to ensure 3 of 4 sampled clients and 1 additional client (clients #1, #2, #4 and #7) were free from physical aggression and Self Injurious Behavior (SIB) and failed to conduct thorough investigations. 2. Please refer to W154. The facility failed for 9 of 9 incidents, involving 3 of 4 sampled clients and 1 additional client (clients #1, #2, #4 and #7), to provide evidence thorough investigations were conducted. 3. Please refer to W157 as the facility | W000122 | The staff has been re-trained on Client Rights/Protections & the Agencies Abuse/Neglect policy (on Friday, August 30, 2013). An investigative form has been implemented to ensure proper thorough investigations are completed; the effective date is: 9/1/13. When client #1 engages in physical aggression, client #1 should be escorted to designated area away from peers in accordance to the BSP. Staff was trained on client #1's BSP on: 8/30/13. The group home manager is responsible for monitoring & ensuring that the staff following the rights of the consumers. In addition, the QDDP will observe during unannounced visits that the staff is following the rights of the consumers. | 09/01/2013 | | | |

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| | <p>failed to take effective corrective action to protect 3 of 4 sampled clients and 1 additional client (clients #1, #2, #4 and #7) from physical aggression.</p> <p>9-3-2(a)</p> | | | | |

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| W000125 | <p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on record review and interview, for 1 of 4 sampled clients (client #1), the facility failed to ensure the client's rights by not obtaining a legally sanctioned decision maker to assist in medical and financial decisions.</p> <p>Findings include:</p> <p>A review of client #1's record was conducted at the facility's administrative office on 7/24/13 at 12:42 P.M.. Client #1's record indicated he was an emancipated adult. Review of client #1's Individual Support Plan (ISP) dated 10/29/12 indicated: "Legal Status: Emancipated...[Client #1] has very limited money skills. He is able to identify a penny and its value; however, he struggles with identifying a quarter, dime and nickel and their values. [Client #1] has always required supports from staff with medication administration. [Client #1] has always required supports from others with medication administration...Will identify a quarter, dime and nickel and their value... Will</p> | W000125 | On 8/30/13, all staff was trained on the Protection of Client Rights. The QDDP retrained staff on client rights & the client rights on decision making, such as: medical & decision makings. The ISP for client #1 has been updated to reflect client #1 is an emancipated adult. The group home manager is responsible for monitoring & ensuring that the staff following the rights of the consumers. In addition, the QDDP will observe during unannounced visits that the staff is following the rights of the consumers. | 09/01/2013 | | | |

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| | <p>learn where my 9 P.M. cream (Ketoconazole 2%) is applied."</p> <p>Further review of client #1's record indicated his diagnoses included, but were not limited to: Coronary Artery Disease, Congested Heart Failure (CHF), Cardiac Arrhythmia, Hypertension, GERD (Gastroesophageal reflux disease), Mood Disorder, Dementia, Neurogenic Bladder, unsteady gait and Glaucoma. Review of the record indicated client #1 has 2 stents, a pacemaker and a defibrillator placed. Review of client #1's "Informed Consent Assessment" (CFA) dated 8/9/12 indicated: "Medical: Requires close supervision/was not capable of: Administers own medication, understand medical interventions, identifies when to seek medical intervention, would probably understand direction during a medical emergency. Money/Financial: Requires close supervision/was not capable of: Understanding basic money concepts, recognizes correct change, makes plans for spending, purchases minor items independently, selects major cash expenditures, saves money and prepares a budget."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was completed at the facility's administrative office on 7/26/13 at 3:14</p> | | | |

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| | <p>P.M.. The QIDP indicated client #1 did not have a legally sanctioned decision maker to assist him with financial and medical decisions. The QIDP further indicated client #1 could not independently manage his finances and was unable to independently make financial and medical decisions.</p> <p>9-3-2(a)</p> | | | |

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| W000149 | <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview, the facility neglected to implement their abuse/neglect policy for 3 of 4 sampled clients and 1 additional client (clients #1, #2, #4 and #7), by not protecting clients from being physically aggressed upon, failed to conduct thorough investigations in regards to client to client aggression and injuries of unknown origin and failed to take sufficient corrective action to address incidents of physical aggression.</p> <p>Findings include:</p> <p>1. A morning observation was conducted at the group home on 7/19/13 from 6:00 A.M. until 7:00 A.M.. At 6:25 A.M., client #1 was sitting in a recliner. Client #1 began yelling profanity and pointing at client #4 who was also sitting in a recliner. Direct Support Professionals (DSP) #1, #2 and #3 were in the living/dining room. Client #1 stood up, moved his walker out from in front of him, walked over to the recliner where client #4 was sitting and began hitting client #4 in his head with a closed fist as DSP #1 was standing next to the recliner. DSPs #1, #2 and #3 did not get between</p> | W000149 | <p>On 8/30/2013, all staff at the Greenwood Group Home received training on the Abuse/Neglect Policy. On 8/30/2013, the staff received training on Client #1's Behavior Support Plan. The staff has also been trained on the seating arrangement when transporting consumers. This change took place due to the behavior of Client #1. An investigative form has been implemented to ensure proper thorough investigations are completed; the effective date is: 9/1/13. The group home manager is responsible for monitoring & ensuring that the staff following the rights of the consumers. In addition, the QDDP will observe during unannounced visits that the staff is following the rights of the consumers.</p> | 09/01/2013 | | | |

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| | <p>client #1 and client #4. DSPs #1, #2 and #3 did not block client #1 from hitting client #4 and did not direct client #1 to time out. Client #4 was not injured. When DSP #1 was asked if client #1 should hit client #4, he stated "No." At 6:45 A.M., client #1 again began using profanity and yelling at client #4. The other clients in the group home began yelling at client #1 telling him to "shut up." When DSP #3 was asked if client #1 had a Behavior Support Plan (BSP) she stated "Yes, but his dementia is getting worse." At 6:55 A.M., DSPs #1, #2 and #3 assisted clients #1, #2, #3, #4, #5, #6, #7 and #8 onto the van to transport to their day program. DSPs #1, #2 and #3 had client #1 sit directly behind client #4 on the inside left first and second row seats. DSPs #1, #2 and #3 were asked if client #1 would aggress upon client #4 again. DSP #3 stated "We don't know, it depends on whoever he decides to start acting out on." When asked why they didn't seat the clients differently, DSP #3 stated "This is the way they sit everyday."</p> <p>A review of client #1's record was conducted on 7/24/13 at 12:42 P.M.. Review of client #1's BSP dated 7/1/13 indicated: "Targeted Behaviors: Verbal Aggression...Physical Aggression...If [client #1] becomes physically aggressive, staff should use their forearm to block his</p> | | | |

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| | <p>attempts to strike or they should move their bodies to avoid a kick." Further review of the BSP indicated when client #1 shows signs of aggression he should be directed to time out.</p> <p>2. A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports was conducted on 7/19/13 at 9:30 A.M.. Review of the reports indicated the following incidents of client to client physical aggression:</p> <p>-BDDS report dated 5/24/13 involving client #4: "On 5/24/13 at approximately 6:20 A.M., [client #1] got upset with his roommate [client #4] as [client #4] received assistance from staff with putting on his jacket and being assisted out to the van (to attend day program at Tradewinds). [Client #1] stood up from his recliner as [client #4] walked towards the door (with staff) and that's when [client #1] hit [client #4] in the upper right side of his top lip. Staff was able to separate the 2 consumers. [Client #4] suffered a small cut on the right side of his top lip. [Client #1] was immediately counseled on appropriate behaviors and his BSP was followed in accordance."</p> <p>-BDDS report dated 5/24/13 involving client #2: "On 5/24/13 at approximately 3:45 P.M., [client #1] got upset with staff,</p> | | | |

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| | <p>because a certain staff member did not pick him up from the day program at Tradewinds. Although he was very unhappy because a particular staff member did not arrive to pick him (sic), he got onto the van with his peers and the 2 staff members (with multiple prompts). While driving, [client #1] was so upset, he tried to unlock the door and that's when another consumer (client #2), who was sitting next to the door hit [client #1]'s hand away from the door. When [client #2] hit [client #1]'s hand from the door, that's when [client #1] hit [client #2] on the right side of the face and [client #2] then hit [client #1] on the upper left shoulder. Staff immediately pulled the van over and put on the hazzards (sic); staff separated both consumers. Both consumers were assessed, there were no visible signs of injury. Neither consumer complained of any pain. Both consumers' (sic) were also counseled on appropriate behaviors. The QDDP arrived at the location and was able to transport [client #1] and his peer (on the van), while the staff person and [client #2] rode together in the QDDP's vehicle. During the ride to the group home, [client #1] calmed down and was able to inform the QDDP that he was upset because his favorite staff person did not arrive to pick him up from the day program and transport him to his home."</p> | | | |

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| | <p>-BDDS report dated 2/1/13 involving client #2: "On 2/1/13 at approximately 5:20 A.M., [client #1] became upset with staff, because staff allowed his roommate to shower first (his roommate was ready and prepared to shower first). [Client #1] was then assisted into the shower after his roommate. However he remained upset with staff and that's when he continued to yell and curse at the staff. As [client #1] completed his shower and walked down the hall (around 6:15 A.M.) (to the dining room area) with staff by his side, he continued to yell and curse at the staff. That's when one of his housemate's (sic) (client #2) got upset and [client #1] started to yell and curse at [client #2]. [Client #2] then pushed [client #1] and [client #1] fell into his recliner chair and then the recliner chair flipped backwards to the floor (with client #1 in the chair). Although the chair fell backwards to the floor with [client #1] sitting in the chair, none of his body parts hit the floor. [Client #1] was assisted off the floor by staff and assessed. There were no visible signs of injury. [Client #1] did not complain of any pain."</p> <p>-BDDS report dated 1/19/13 involving client #4: "On 1/19/13 at approximately 9:30 A.M., staff noticed [client #4] with a black/blue/purple bruise underneath his</p> | | | | |

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| | <p>right eye. When staff asked [client #4] what happened, he stated [client #2] 'Hit me.' When staff asked [client #2] what happened, he stated that [client #4] was yelling, screaming, hitting the wall, banging his feet on the floor and banging his bed against the wall and he stated that he was unable to sleep. [Client #2] stated he got up from his bedroom and entered into the bedroom of [client #4] and told him to stop and that's when he stated [client #4] tried to hit him (but was not successful) and that's when he got upset and hit [client #4] in the right eye. [Client #2] stated he went back to his room and went to bed."</p> <p>-BDDS report dated 9/24/12 involving client #1: "[Client #1] was talking to staff and another consumer got upset. The other consumer walked up to [client #1] and grabbed [client #1], attempting to hit him and that's when [client #1] hit the other consumer on the right side of his face before staff could separate (sic) them. Staff did intervene and was able to separate (sic) both consumers and redirect them. Staff completed an assessment on the other consumer checking for injuries however, there were no injuries as a result of this incident."</p> <p>-BDDS report dated 8/28/12 involving client #2: "On 8/28/12, while on break,</p> | | | |

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| | <p>[client #7] approached [client #2] and smacked him in the face without provocation. The two were immediately seperated (sic) by staff without further incident."</p> <p>3. A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports was conducted on 7/19/13 at 9:30 A.M.. Review of the BDDS reports indicated the following:</p> <p>-BDDS report dated 7/1/13 involving client #1: "On 7/1/13, staff at Trade Winds Day Program informed the QDDP (Qualified Developmental Disabilities Professional) that [client #1] (sic) left hand looked to be swollen. When staff assessed [client #1]'s hand, it was sore to touch. Staff took [client #1] to [Urgent Care] to get [client #1]'s hand assessed. An x-ray of [client #1]'s hand (sic) and the results of the x-ray was [client #1]'s left hand is fractured. [Client #1]'s left hand was treated by the physician at [Urgent Care] and he will follow up with a physician on 7/3/13." No documentation was submitted for review to indicate the facility conducted a thorough investigation of this incident of unknown injury.</p> <p>-BDDS report dated 5/24/13 involving client #2: "On 5/24/13 at approximately</p> | | | |

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| | <p>3:45 P.M., [client #1] got upset with staff, because a certain staff member did not pick him up from the day program at Tradewinds. Although he was very unhappy because a particular staff member did not arrive to pick him (sic), he got onto the van with his peers and the 2 staff members (with multiple prompts). While driving, [client #1] was so upset, he tried to unlock the door and that's when another consumer (client #2), who was sitting next to the door hit [client #1]'s hand away from the door. When [client #2] hit [client #1]'s hand from the door, that's when [client #1] hit [client #2] on the right side of the face and [client #2] then hit [client #1] on the upper left shoulder. Staff immediately pulled the van over and put on the hazzards (sic); staff separated both consumers. Both consumers were assessed, there were no visible signs of injury. Neither consumer complained of any pain. Both consumers' (sic) were also counseled on appropriate behaviors. The QDDP arrived at the location and was able to transport [client #1] and his peer (on the van), while the staff person and [client #2] rode together in the QDDP's vehicle. During the ride to the group home, [client #1] calmed down and was able to inform the QDDP that he was upset because his favorite staff person did not arrive to pick him up from the day program and transport him to his</p> | | | |

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| | <p>home." No documentation was submitted for review to indicate the facility conducted a thorough investigation in regards to this incident.</p> <p>-BDDS report dated 3/14/13 involving client #4: "Staff observed a bruise on [client #4]'s right upper arm the bruise was About (sic) 2 inches long and yellow. He was asked how this happened. He stated he did not know." No documentation was submitted for review to indicate the facility conducted a thorough investigation in regards to this injury of unknown origin.</p> <p>-BDDS report dated 3/12/13 involving client #1: "On 3/13/13 at approximately 3:48 A.M., [client #1] fell out of bed. Once staff heard the noise, staff ran into [client #1]'s room and that's when staff found [client #1] lying on the floor. [Client #1] stated, he fell out of bed when he tried to roll onto his back to get out of bed, so that he can use the restroom. Staff assisted [client #1] off floor and assessed [client #1]. [Client #1] suffered a small scrape on his forehead. Staff applied antibiotic ointment to the small scrape on his forehead. [Client #1] stated he is ok. He did not suffer any additional injuries from this incident." No documentation was submitted for review to indicate the facility conducted a</p> | | | | | | |

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| | <p>thorough investigation of the injury of unknown origin.</p> <p>-BDDS report dated 2/1/13 involving client #2: "On 2/1/13 at approximately 5:20 A.M., [client #1] became upset with staff, because staff allowed his roommate to shower first (his roommate was ready and prepared to shower first). [Client #1] was then assisted into the shower after his roommate. However he remained upset with staff and that's when he continued to yell and curse at the staff. As [client #1] completed his shower and walked down the hall (around 6:15 A.M.) (to the dining room area) with staff by his side, he continued to yell and curse at the staff. That's when one of his housemate's (sic) (client #2) got upset and [client #1] started to yell and curse at [client #2]. [Client #2] then pushed [client #1] and [client #1] fell into his recliner chair and then the recliner chair flipped backwards to the floor (with client #1 in the chair). Although the chair fell backwards to the floor with [client #1] sitting in the chair, none of his body parts hit the floor. [Client #1] was assisted off the floor by staff and assessed. There were no visible signs of injury. [Client #1] did not complain of any pain." No documentation was submitted for review to indicate the facility conducted a thorough investigation in regards to this</p> | | | | | | |

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| | <p>incident.</p> <p>-BDDS report dated 1/19/13 involving client #4: "On 1/19/13 at approximately 9:30 A.M., staff noticed [client #4] with a black/blue/purple bruise underneath his right eye. When staff asked [client #4] what happened, he stated [client #2] 'Hit me.' When staff asked [client #2] what happened, he stated that [client #4] was yelling, screaming, hitting the wall, banging his feet on the floor and banging his bed against the wall and he stated that he was unable to sleep. [Client #2] stated he got up from his bedroom and entered into the bedroom of [client #4] and told him to stop and that's when he stated [client #4] tried to hit him (but was not successful) and that's when he got upset and hit [client #4] in the right eye. [Client #2] stated he went back to his room and went to bed." No documentation was submitted for review to indicate the facility conducted a thorough investigation in regards to this incident.</p> <p>-BDDS report dated 9/24/12 involving client #1: "[Client #1] was talking to staff and another consumer got upset. The other consumer walked up to [client #1] and grabbed [client #1], attempting to hit him and that's when [client #1] hit the other consumer on the right side of his face before staff could separate (sic)</p> | | | |

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| | <p>them. Staff did intervene and was able to separate (sic) both consumers and redirect them. Staff completed an assessment on the other consumer checking for injuries however, there were no injuries as a result of this incident." No documentation was available for review to indicate the facility took effective corrective action after this incident.</p> <p>-BDDS report dated 8/28/12 involving client #2: "On 8/28/12, while on break, [client #7] approached [client #2] and smacked him in the face without provocation. The two were immediately seperated (sic) by staff without further incident." No documentation was submitted for review to indicate the facility conducted a thorough investigation in regards to this incident.</p> <p>A review of the facility's abuse/neglect policy date 4/20/10 was conducted at the facility's administrative office on 7/25/13 at 11:00 A.M.. Review of the policy indicated: "To establish prompt, accurate and effective procedures and investigating of all allegations of abuse and neglect and any incident or crime as defined...All allegations of abuse and neglect of consumers served and certain other incidents defined in this policy are to be reported and investigated in prompt and procedurally correct manner...Accidents</p> | | | |

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| | <p>and other injuries not defined as abuse or neglect must still be documented on the incident report form and reviewed according to policy and applicable standards...It is mandatory that all personnel follow this policy. This includes: reporting incidents immediately upon becoming aware of them, completing all forms as required by this policy...Physical abuse: willful infliction of injury...Verbal abuse: Oral, written and or gestured language that includes disparaging and derogatory remarks toward consumers...Injuries of unknown origin, in addition all injuries of unknown origin must be reported to Adult Protective Services within 24 hours of the injury being discovered. A complete investigation of the injury must be conducted by the Qualified Mental Retardation Professional (QMRP) or the Residential Coordinator...All staff with knowledge of the incident must complete a copy of the unknown injury report and forward it to the QMRP by the end of their shift...Inadequate medical support: including but not limited to failure to obtain needed follow-up medical appointments, failure to obtain routine dental or physician appointments, or failure to obtain medication refills in a timely manner."</p> <p>An interview with the Qualified</p> | | | | |

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| | <p>Intellectual Disabilities Professional (QIDP) was conducted on 7/19/13 at 9:45 A.M.. The QIDP stated "We do not have a system in place where we document an actual investigation." The QIDP further indicated DSPs #1, #2 and #3 should have intervened before client #1 was able to hit client #4.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted at the facility's administrative office on 7/26/13 at 4:30 P.M.. The QIDP indicated there were no investigations conducted and no investigation files were available for review. The QIDP further indicated all staff are aware of the facility's abuse/neglect policy and procedure and should implement it at all times.</p> <p>9-3-2(a)</p> | | | |

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| W000154 | <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 9 of 9 incidents of client to client physical aggression and injuries of unknown origin, involving 3 of 4 sampled clients and 1 additional client (clients #1, #2, #4 and #7), the facility failed to provide written evidence thorough investigations were conducted.</p> <p>Findings include:</p> <p>1. A morning observation was conducted at the group home on 7/19/13 from 6:00 A.M. until 7:00 A.M.. At 6:25 A.M., client #1 was sitting in a recliner. Client #1 began yelling profanity and pointing at client #4 who was also sitting in a recliner. Direct Support Professionals (DSP) #1, #2 and #3 were in the living/dining room. Client #1 stood up, moved his walker out from in front of him, walked over to the recliner where client #4 was sitting and began hitting client #4 in his head with a closed fist as DSP #1 was standing next to the recliner. DSPs #1, #2 and #3 did not get between client #1 and client #4. DSPs #1, #2 and #3 did not block client #1 from hitting client #4 and did not direct client #1 to time out. When DSP #1 was asked if</p> | W000154 | On 8/30/2013, all staff at the Greenwood Group Home received training on the Abuse/Neglect Policy. On 8/30/2013, the staff received training on Client #1's Behavior Support Plan. The staff has also been trained on the seating arrangement when transporting consumers. This change took place due to the behavior of Client #1. An investigative form has been implemented to ensure proper thorough investigations are completed; the effective date is: 9/1/13. The group home manager is responsible for monitoring & ensuring that the staff following the rights of the consumers. In addition, the QDDP will observe during unannounced visits that the staff is following the rights of the consumers. | 09/01/2013 |

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| | <p>client #1 should hit client #4 he stated "No." At 6:45 A.M., client #1 again began using profanity and yelling at client #4. The other clients in the group home began yelling at client #1 telling him to "shut up". When DSP #3 was asked if client #1 had a Behavior Support Plan (BSP) she stated "Yes, but his dementia is getting worse." At 6:55 A.M., DSPs #1, #2 and #3 assisted clients #1, #2, #3, #4, #5, #6, #7 and #8 onto the van to transport to their day program. DSPs #1, #2 and #3 had client #1 sit directly behind client #4 on the inside left first and second row seats. DSPs #1, #2 and #3 were asked if client #1 would aggress upon client #4 again. DSP #3 stated "We don't know, it depends on whoever he decides to start acting out on." When asked why they didn't seat the clients differently, DSP #3 stated "This is the way they sit everyday."</p> <p>A review of the facility's records was conducted at the facility's administrative office on 7/19/13 at 8:35 A.M.. A request for all investigation files from 7/1/12 to 7/19/13 was made to the Qualified Intellectual Disabilities Professional (QIDP). No investigation files were available for review to indicate any investigations were completed. No thorough investigation was completed in regards to the 7/19/13 incident involving</p> | | | |

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| | <p>clients #1 and #4.</p> <p>2. A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports was conducted on 7/19/13 at 9:30 A.M.. Review of the reports indicated:</p> <p>-BDDS report dated 7/1/13 involving client #1: "On 7/1/13, staff at Trade Winds Day Program informed the QDDP (Qualified Developmental Disabilities Professional) that [client #1] (sic) left hand looked to be swollen. When staff assessed [client #1]'s hand, it was sore to touch. Staff took [client #1] to [Urgent Care] to get [client #1]'s hand assessed. An x-ray of [client #1]'s hand (sic) and the results of the x-ray was [client #1]'s left hand is fractured. [Client #1]'s left hand was treated by the physician at [Urgent Care] and he will follow up with a physician on 7/3/13." No documentation was submitted for review to indicate the facility conducted a thorough investigation of this incident.</p> <p>-BDDS report dated 5/24/13 involving client #2: "On 5/24/13 at approximately 3:45 P.M., [client #1] got upset with staff, because a certain staff member did not pick him up from the day program at Tradewinds. Although he was very unhappy because a particular staff</p> | | | | | | |

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| | <p>member did not arrive to pick him (sic), he got onto the van with his peers and the 2 staff members (with multiple prompts). While driving, [client #1] was so upset, he tried to unlock the door and that's when another consumer (client #2), who was sitting next to the door hit [client #1]'s hand away from the door. When [client #2] hit [client #1]'s hand from the door, that's when [client #1] hit [client #2] on the right side of the face and [client #2] then hit [client #1] on the upper left shoulder. Staff immediately pulled the van over and put on the hazzards (sic); staff seperated both consumers. Both consumers were assessed, there were no visible signs of injury. Neither consumer complained of any pain. Both consumers' (sic) were also counseled on appropriate behaviors. The QDDP arrived at the location and was able to transport [client #1] and his peer (on the van), while the staff person and [client #2] rode together in the QDDP's vehicle. During the ride to the group home, [client #1] calmed down and was able to inform the QDDP that he was upset because his favorite staff person did not arrive to pick him up from the day program and transport him to his home." No documentation was submitted for review to indicate the facility conducted a thorough investigation in regards to this incident.</p> | | | |

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| | <p>-BDDS report dated 3/14/13 involving client #4: "Staff observed a bruise on [client #4]'s right upper arm the bruise was About (sic) 2 inches long and yellow. He was asked how this happened. He stated he did not know." No documentation was submitted for review to indicate the facility conducted a thorough investigation in regards to this injury of unknown origin.</p> <p>-BDDS report dated 3/12/13 involving client #1: "On 3/13/13 at approximately 3:48 A.M., [client #1] fell out of bed. Once staff heard the noise, staff ran into [client #1]'s room and that's when staff found [client #1] lying on the floor. [Client #1] stated, he fell out of bed when he tried to roll onto his back to get out of bed, so that he can use the restroom. Staff assisted [client #1] off floor and assessed [client #1]. [Client #1] suffered a small scrape on his forehead. Staff applied antibiotic ointment to the small scrape on his forehead. [Client #1] stated he is ok. He did not suffer any additional injuries from this incident." No documentation was submitted for review to indicate the facility conducted a thorough investigation of the injury of unknown origin.</p> <p>-BDDS report dated 2/1/13 involving client #2: "On 2/1/13 at approximately</p> | | | |

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| | <p>5:20 A.M., [client #1] became upset with staff, because staff allowed his roommate to shower first (his roommate was ready and prepared to shower first). [Client #1] was then assisted into the shower after his roommate. However he remained upset with staff and that's when he continued to yell and curse at the staff. As [client #1] completed his shower and walked down the hall (around 6:15 A.M.) (to the dining room area) with staff by his side, he continued to yell and curse at the staff. That's when one of his housemate's (sic) (client #2) got upset and [client #1] started to yell and curse at [client #2]. [Client #2] then pushed [client #1] and [client #1] fell into his recliner chair and then the recliner chair flipped backwards to the floor (with client #1 in the chair). Although the chair fell backwards to the floor with [client #1] sitting in the chair, none of his body parts hit the floor. [Client #1] was assisted off the floor by staff and assessed. There were no visible signs of injury. [Client #1] did not complain of any pain." No documentation was submitted for review to indicate the facility conducted a thorough investigation in regards to this incident.</p> <p>-BDDS report dated 1/19/13 involving client #4: "On 1/19/13 at approximately 9:30 A.M., staff noticed [client #4] with a</p> | | | |

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| NAME OF PROVIDER OR SUPPLIER TRADEWINDS SERVICES INC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 220 E GREENWOOD CROWN POINT, IN 46307 | | | |
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| | <p>black/blue/purple bruise underneath his right eye. When staff asked [client #4] what happened, he stated [client #2] 'Hit me.' When staff asked [client #2] what happened, he stated that [client #4] was yelling, screaming, hitting the wall, banging his feet on the floor and banging his bed against the wall and he stated that he was unable to sleep. [Client #2] stated he got up from his bedroom and entered into the bedroom of [client #4] and told him to stop and that's when he stated [client #4] tried to hit him (but was not successful) and that's when he got upset and hit [client #4] in the right eye. [Client #2] stated he went back to his room and went to bed." No documentation was submitted for review to indicate the facility conducted a thorough investigation in regards to this incident.</p> <p>-BDDS report dated 9/24/12 involving client #1: "[Client #1] was talking to staff and another consumer got upset. The other consumer walked up to [client #1] and grabbed [client #1], attempting to hit him and that's when [client 31] hit the other consumer on the right side of his face before staff could separate (sic) them. Staff did intervene and was able to separate (sic) both consumers and redirect them. Staff completed an assessment on the other consumer checking for injuries however, there were no injuries as a result</p> | | | | | | |

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| | <p>of this incident."</p> <p>-BDDS report dated 8/28/12 involving client #2: "On 8/28/12, while on break, [client #7] approached [client #2] and smacked him in the face without provocation. The two were immediately seperated (sic) by staff without further incident." No documentation was submitted for review to indicate the facility conducted a thorough investigation in regards to this incident.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 7/19/13 at 9:45 A.M.. The QIDP stated "We do not have a system in place where we document an actual investigation."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted at the facility's administrative office on 7/26/13 at 4:30 P.M.. The QIDP indicated there were no investigations conducted and no investigation files were available for review.</p> <p>9-3-2(a)</p> | | | | | | |

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| W000157 | <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on observation, record review and interview, the facility failed for 3 of 4 sampled clients and 1 additional client (clients #1, #2, #4 and #7) to take effective corrective action for 6 of 6 reported incidents of client to client aggression.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 7/19/13 from 6:00 A.M. until 7:00 A.M.. At 6:25 A.M., client #1 was sitting in a recliner. Client #1 began yelling profanity and pointing at client #4 who was also sitting in a recliner. Direct Support Professionals (DSP) #1, #2 and #3 were in the living/dining room. Client #1 stood up, moved his walker out from in front of him, walked over to the recliner where client #4 was sitting and began hitting client #4 in his head with a closed fist as DSP #1 was standing next to the recliner. DSPs #1, #2 and #3 did not get between client #1 and client #4. DSPs #1, #2 and #3 did not block client #1 from hitting client #4 and did not direct client #1 to time out. When DSP #1 was asked if client #1 should hit client #4 he stated "No." At 6:45 A.M., client #1 again</p> | W000157 | On 8/30/2013, all staff at the Greenwood Group Home received training on the Abuse/Neglect Policy. On 8/30/2013, the staff received training on Client #1's Behavior Support Plan. The staff has also been trained on the seating arrangement when transporting consumers. This change took place due to the behavior of Client #1. An investigative form has been implemented to ensure proper thorough investigations are completed; the effective date is: 9/1/13. The group home manager is responsible for monitoring & ensuring that the staff following the rights of the consumers. In addition, the QDDP will observe during unannounced visits that the staff is following the rights of the consumers. | 09/01/2013 | | | |

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| | <p>began using profanity and yelling at client #4. The other clients in the group home began yelling at client #1 telling him to "shut up". When DSP #3 was asked if client #1 had a Behavior Support Plan (BSP) she stated "Yes, but his dementia is getting worse." At 6:55 A.M., DSPs #1, #2 and #3 assisted clients #1, #2, #3, #4, #5, #6, #7 and #8 onto the van to transport to their day program. DSPs #1, #2 and #3 had client #1 sit directly behind client #4 on the inside left first and second row seats. DSPs #1, #2 and #3 were asked if client #1 would aggress upon client #4 again. DSP #3 stated "We don't know, it depends on whoever he decides to start acting out on." When asked why they didn't seat the clients differently, DSP #3 stated "This is the way they sit everyday."</p> <p>A review of the facility's BDDS reports was conducted on 7/19/13 at 9:30 A.M.. Review of the reports indicated:</p> <p>-BDDS report dated 5/24/13 involving client #4: "On 5/24/13 at approximately 6:20 A.M., [client #1] got upset with his roommate [client #4] as [client #4] received assistance from staff with putting on his jacket and being assisted out to the van (to attend day program at Tradewinds). [Client #1] stood up from his recliner as [client #4] walked towards</p> | | | | | | |

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| | <p>the door (with staff) and that's when [client #1] hit [client #4] in the upper right side of his top lip. Staff was able to separate the 2 consumers. [Client #4] suffered a small cut on the right side of his top lip. [Client #1] was immediately counseled on appropriate behaviors and his BSP was followed in accordance."</p> <p>-BDDS report dated 5/24/13 involving client #2: "On 5/24/13 at approximately 3:45 P.M., [client #1] got upset with staff, because a certain staff member did not pick him up from the day program at Tradewinds. Although he was very unhappy because a particular staff member did not arrive to pick him (sic), he got onto the van with his peers and the 2 staff members (with multiple prompts). While driving, [client #1] was so upset, he tried to unlock the door and that's when another consumer (client #2), who was sitting next to the door hit [client #1]'s hand away from the door. When [client #2] hit [client #1]'s hand from the door, that's when [client #1] hit [client #2] on the right side of the face and [client #2] then hit [client #1] on the upper left shoulder. Staff immediately pulled the van over and put on the hazzards (sic); staff seperated both consumers. Both consumers were assessed, there were no visible signs of injury. Neither consumer complained of any pain. Both consumers'</p> | | | |

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| | <p>(sic) were also counseled on appropriate behaviors. The QDDP arrived at the location and was able to transport [client #1] and his peer (on the van), while the staff person and [client #2] rode together in the QDDP's vehicle. During the ride to the group home, [client #1] calmed down and was able to inform the QDDP that he was upset because his favorite staff person did not arrive to pick him up from the day program and transport him to his home." No documentation was available for review to indicate the facility took effective corrective action after this incident.</p> <p>-BDDS report dated 2/1/13 involving client #2: "On 2/1/13 at approximately 5:20 A.M., [client #1] became upset with staff, because staff allowed his roommate to shower first (his roommate was ready and prepared to shower first). [Client #1] was then assisted into the shower after his roommate. However he remained upset with staff and that's when he continued to yell and curse at the staff. As [client #1] completed his shower and walked down the hall (around 6:15 A.M.) (to the dining room area) with staff by his side, he continued to yell and curse at the staff. That's when one of his housemate's (sic) (client #2) got upset and [client #1] started to yell and curse at [client #2]. [Client #2] then pushed [client #1] and</p> | | | |
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| | <p>[client #1] fell into his recliner chair and then the recliner chair flipped backwards to the floor (with client #1 in the chair). Although the chair fell backwards to the floor with [client #1] sitting in the chair, none of his body parts hit the floor. [Client #1] was assisted off the floor by staff and assessed. There were no visible signs of injury. [Client #1] did not complain of any pain." No documentation was available for review to indicate the facility took effective corrective action after this incident.</p> <p>-BDDS report dated 1/19/13 involving client #4: "On 1/19/13 at approximately 9:30 A.M., staff noticed [client #4] with a black/blue/purple bruise underneath his right eye. When staff asked [client #4] what happened, he stated [client #2] 'Hit me.' When staff asked [client #2] what happened, he stated that [client #4] was yelling, screaming, hitting the wall, banging his feet on the floor and banging his bed against the wall and he stated that he was unable to sleep. [Client #2] stated he got up from his bedroom and entered into the bedroom of [client #4] and told him to stop and that's when he stated [client #4] tried to hit him (but was not successful) and that's when he got upset and hit [client #4] in the right eye. [Client #2] stated he went back to his room and went to bed." No documentation was</p> | | | |

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| | <p>available for review to indicate the facility took effective corrective action after this incident.</p> <p>-BDDS report dated 9/24/12 involving client #1: "[Client #1] was talking to staff and another consumer got upset. The other consumer walked up to [client #1] and grabbed [client #1], attempting to hit him and that's when [client 31] hit the other consumer on the right side of his face before staff could separate (sic) them. Staff did intervene and was able to separate (sic) both consumers and redirect them. Staff completed an assessment on the other consumer checking for injuries however, there were no injuries as a result of this incident." No documentation was available for review to indicate the facility took effective corrective action after this incident.</p> <p>-BDDS report dated 8/28/12 involving client #2: "On 8/28/12, while on break, [client #7] approached [client #2] and smacked him in the face without provocation. The two were immediately seperated (sic) by staff without further incident." No documentation was available for review to indicate the facility took effective corrective action after this incident.</p> <p>An interview with the Qualified</p> | | | | | | |

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| | <p>Intellectual Disabilities Professional (QIDP) was conducted at the facility's administrative office on 7/26/13 at 4:30 P.M.. When asked if the Inter Disciplinary Team (IDT) met to address each of the mentioned incidents, the QIDP stated "No." When asked if any changes to the clients' programs had been made to address the clients' documented aggression, the QIDP stated "No." The QIDP indicated there was no documentation available for review to indicate the facility took effective corrective action to address each of these incidents involving clients #1, #2, #4 and #7.</p> <p>9-3-2(a)</p> | | | |

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| W000189 | <p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on record review and interview, the facility failed for 1 of 4 sampled clients (client #4) to ensure staff were sufficiently trained to address client #1's behavior to prevent client #4 from being physically aggressed upon.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 7/19/13 from 6:00 A.M. until 7:00 A.M.. At 6:25 A.M., client #1 was sitting in a recliner. Client #1 began yelling profanity and pointing at client #4 who was also sitting in a recliner. Direct Support Professionals (DSP) #1, #2 and #3 were in the living/dining room. Client #1 stood up, moved his walker out from in front of him, walked over to the recliner where client #4 was sitting and began hitting client #4 in his head with a closed fist as DSP #1 was standing next to the recliner. DSPs #1, #2 and #3 did not get between client #1 and client #4. DSPs #1, #2 and #3 did not block client #1 from hitting client #4 and did not direct client #1 to time out. When DSP #1 was asked if</p> | W000189 | <p>On 8/30/2013, all staff at the Greenwood Group Home received training on the Behavior Support Plan for client #1. All staff were trained on client #1 targeted behaviors, which includes: Verbal Aggression, Physical Aggression, Inappropriate attention seeking, Non-Compliance & Wandering. All staff were also trained on the replacement behaviors for client #1, which includes: Social Skills (Client #1 will engage in appropriate social skills with peers at work & his roommates at home including confronting others appropriately & accepting "NO);" Following a structured routine (Client #1 will follow a daily routine that will include chores, activities, hygiene & community outings);" & Coping Skills (Client #1 will engage in appropriate coping skills during times of agitation)." All staff was trained on the communication goal for client #1 on 8/30/2013. The group manager is also responsible for monitoring the staff to ensure that the ISPs are being implemented. In addition, the QDDP will observe staff during unannounced visits to the group home to ensure that staff is following & implementing the</p> | 09/01/2013 | | | |

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| | <p>client #1 should hit client #4 he stated "No." At 6:45 A.M., client #1 again began using profanity and yelling at client #4. The other clients in the group home began yelling at client #1 telling him to "shut up". When DSP #3 was asked if client #1 had a Behavior Support Plan (BSP), she stated "Yes, but his dementia is getting worse." At 6:55 A.M., DSPs #1, #2 and #3 assisted clients #1, #2, #3, #4, #5, #6, #7 and #8 onto the van to transport to their day program. DSPs #1, #2 and #3 had client #1 sit directly behind client #4 on the inside left first and second row seats. DSPs #1, #2 and #3 were asked if client #1 would aggress upon client #4 again. DSP #3 stated "We don't know, it depends on whoever he decides to start acting out on." When asked why they didn't seat the clients differently, DSP #3 stated "This is the way they sit everyday."</p> <p>A review of client #1's record was conducted on 7/24/13 at 12:42 P.M.. Review of client #1's BSP dated 7/1/13 indicated: "Targeted Behaviors: Verbal Aggression...Physical Aggression...If [client #1] becomes physically aggressive, staff should use their forearm to block his attempts to strike or they should move their bodies to avoid a kick." Further review of the BSP indicated when client #1 shows signs of aggression he should be</p> | | ISPs. | |

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| | <p>directed to time out.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 7/26/13 at 4:30 P.M.. When asked if group home staff were trained on client #1's Behavior Support Plan (BSP), the QIDP stated "Yes, all staff are trained on clients' programs and BSPs prior to working at the group home." When asked if DSPs #1, #2 and #3 should have intervened before client #1 became physically aggressive towards client #4, the QIDP stated "Yes."</p> <p>9-3-3(a)</p> | | | | |

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| W000227 | <p>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 comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, interview and record review, the client's interdisciplinary team (IDT) failed to address the client's identified training needs in regards to physical communication for 1 of 4 sampled clients (client #1).</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 7/19/13 from 6:00 A.M. until 7:00 A.M.. During the entire observation period client #1 could not be understood when communicating with others.</p> <p>An evening observation was conducted at the group home on 7/22/13 from 4:20 P.M. until 6:40 P.M.. During the entire observation period client #1 could not be understood when communicating with others.</p> <p>A facility owned day program observation was conducted on 7/24/13 from 11:50 A.M. until 1:00 P.M.. During the entire observation period client #1 could not be</p> | W000227 | <p>On 8/30/2013, all staff at the Greenwood Group Home received training on the Behavior Support Plan for client #1. All staff were trained on client #1 targeted behaviors, which includes: Verbal Aggression, Physical Aggression, Inappropriate attention seeking, Non-Compliance & Wandering. All staff were also trained on the replacement behaviors for client #1, which includes: Social Skills (Client #1 will engage in appropriate social skills with peers at work & his roommates at home including confronting others appropriately & accepting "NO);” Following a structured routine (Client #1 will follow a daily routine that will include chores, activities, hygiene & community outings);” & Coping Skills (Client #1 will engage in appropriate coping skills during times of agitation).” All staff was trained on the communication goal for client #1 on 8/30/2013. . The group manager is also responsible for monitoring the staff to ensure that the ISPs are being implemented. In addition, the QDDP will observe staff during unannounced visits to the group home to ensure that staff is following & implementing the</p> | 09/01/2013 | | | |

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| | <p>understood when communicating with others.</p> <p>A review of client #1's record was conducted on 7/24/13 at 12:42 P.M.. Review of client #1's Individual Support Plan (ISP) dated 10/29/12 indicated: "Speaking Difficulties: [Client #1] is verbal, however, his speech can be difficult to understand." Client #1's ISP indicated he did not receive formal training in regard to communication.</p> <p>Review of client #1's "Informed Consent Assessment" dated 8/9/12 indicated client #1 required assistance in communication.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 7/26/13 at 3:14 P.M.. The QIDP indicated client #1's ISP did not address the client's identified training need in regard to communication.</p> <p>9-3-4(a)</p> | | ISPs. | | |

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| W000249 | <p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review and interview for 4 of 4 sampled clients (clients #1, #2, #3 and #4), the facility failed to implement the clients' training objectives when formal and/or informal opportunities existed at the group home.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 7/19/13 from 6:00 A.M. until 7:00 A.M.. During the entire observation period, clients #1, #2, #3 and #4 sat in the living room with no activity. Direct Support Professionals (DSP) #1, #2 and #3 would walk into the room and occasionally check on clients #1, #2, #3 and #4, but did not offer any meaningful activity. At 6:25 A.M., client #1 was sitting in a recliner. Client #1 began yelling profanity and pointing at client #4 who was also sitting in a recliner. DSP #1, #2 and #3 were in the living/dining room. Client #1 stood up, moved his walker out from in front of him, walked over to the recliner where client #4 was</p> | W000249 | A Meaningful Day Activity Schedule will be developed & implemented into the Greenwood Group Home for all consumers' effective 9/1/13. This schedule will allow staff guidance for activities throughout the day for each consumer. The Meaningful Day Activity Schedule outlines active treatment opportunities, training objectives & various activities for the consumers to be involved in & etc. The group home manager is responsible for monitoring the staff to ensure that the proper procedure is being followed & that all consumers are actively involved in their own care. In addition, the QDDP will observe staff during unannounced visits to the group home to ensure that staff is following the proper procedure of all consumers being actively involved in their own care. | 09/01/2013 | | | |

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| | <p>sitting and began hitting client #4 in his head with a closed fist as DSP #1 was standing next to the recliner. DSPs #1, #2 and #3 did not get between client #1 and client #4. Client #4 was not injured. DSPs #1, #2 and #3 did not block client #1 from hitting client #4 and did not direct client #1 to time out.</p> <p>An evening observation was conducted at the group home on 7/22/13 from 4:20 P.M. until 6:40 P.M.. During the entire observation period, clients #1, #2, #3 and #4 sat in the living/dining room area with no activity. DSP #1, #4 and #5 would walk into the room and occasionally check on clients #1, #2, #3 and #4, but did not offer any meaningful activity.</p> <p>A review of client #1's record was conducted on 7/24/13 at 12:42 P.M.. A review of client #1's Individual Support Plan (ISP) dated 10/29/12 indicated the following objectives that could have been implemented during both observations: "Will identify a quarter, dime, and nickel and their value...Will learn where my 9 P.M., cream is applied...Will engage in appropriate social skills with my peers...Will follow a daily schedule." Review of client #1's BSP dated 7/1/13 indicated: "Targeted Behaviors: Verbal Aggression...Physical Aggression...If [client #1] becomes physically aggressive,</p> | | | |

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| | <p>staff should use their forearm to block his attempts to strike or they should move their bodies to avoid a kick." Further review of the BSP indicated when client #1 shows signs of aggression he should be directed to time out. DSPs #1, #2 and #3 did not implement client #1's BSP during the 7/19/13 morning observation.</p> <p>A review of client #2's record was conducted on 7/25/13 at 3:00 P.M.. The ISP dated 10/25/12 indicated the following objectives that could have been implemented during both observations: "Will count my change after making a purchase...Will learn the name and purpose of two of my medications...Will recite my address and telephone number."</p> <p>A review of client #3's record was conducted on 7/25/13 at 11:20 A.M.. The ISP dated 8/1/12 indicated the following objectives that could have been implemented during both observations: "Will learn my personal information (address and telephone number)...Will learn to add various coins up to \$1...Will learn the value of money...Will work on coping skills...Will work on my social skills."</p> <p>A review of client #4's record was conducted on 7/25/13 at 1:15 P.M.. The ISP dated 6/19/13 indicated the following</p> | | | | | | |

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| | <p>objectives that could have been implemented during both observations: "Will use picture schedule to shower/bath (sic)... Will learn the times I take my medications... Will learn to add pennies up to 5 cents...."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 7/26/13 at 3:15 P.M.. The QIDP indicated facility staff should implement training objectives at all times of opportunity. The QIDP further indicated staff should implement clients' BSPs as written.</p> <p>9-3-4(a)</p> | | | | |

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| W000250 | <p>483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. Based on record review and interview, the facility failed for 4 of 4 sampled clients (clients #1, #2, #3 and #4) to have Active Treatment Schedules (ATS).</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 7/24/13 at 12:42 P.M.. Client #1's record did not include an ATS.</p> <p>Client #2's record was reviewed on 7/25/13 at 3:00 P.M.. Client #2's record did not include an ATS.</p> <p>Client #3's record was reviewed on 7/25/13 at 11:20 A.M.. Client #3's record did not include an ATS.</p> <p>Client #4's record was reviewed on 7/25/13 at 1:15 P.M.. Client #4's record did not include an ATS.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 7/26/13 at 3:15 P.M.. The QIDP indicated clients #1, #2, #3 and #4 did not have an ATS.</p> | W000250 | A Meaningful Day Activity Schedule will be developed & implemented into the Greenwood Group Home for all consumers' effective 9/1/13. This schedule will allow staff guidance for activities throughout the day for each consumer. The Meaningful Day Activity Schedule outlines active treatment opportunities, training objectives & various activities for the consumers to be involved in & etc. The group home manager is responsible for monitoring the staff to ensure that the proper procedure is being followed & that all consumers are actively involved in their own care. In addition, the QDDP will observe staff during unannounced visits to the group home to ensure that staff is following the proper procedure of all consumers being actively involved in their own care. | 09/01/2013 | |

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| W000331 | <p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 1 of 2 clients observed during the evening medication administration, (client #1), the facility's nursing services failed to reconcile doctor's orders with labels and Medication Administration Records (MAR).</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 7/22/13 from 4:20 P.M. until 6:40 P.M.. At 5:51 P.M. Direct Support Professional (DSP) #4 tested client #1's blood pressure which read at 116/62. DSP #4 then administered client #1's prescribed oral medication. DSP #4 stated "[Client #1] doesn't get his Amlodipine Besylate 5 mg (milligram) tablet because the bottom number in his blood pressure reading was under 70." A review of the Medication Administration Record (MAR) dated 7/1/13 to 7/31/13 indicated: "Amlodipine Besylate 5 mg tablet...1 tablet twice daily." Review of the medication packet label indicated "Amlodipine Besylate 5 mg tablet...1 tablet twice daily." The MAR and medication label did not indicate to hold the medication if the diastolic reading is</p> | W000331 | <p>The following is Tradewinds policy for distribution of monthly medications:</p> <ol style="list-style-type: none"> 1. Medications are prepared by the pharmacy by unit dose & are picked up by the Residential Nurse along with an MAR sheet & Physician order sheet for each client. 2. The Residential Nurse must check all medications prior to their delivery to homes. This includes matching the physician order to the medication & MAR sheet. The Residential Nurse will correct any errors prior to the delivery of medications. 3. Medications, MAR sheets & Physician order sheets are then delivered to the homes, where the designated staff again checks the medication label to the MAR sheet & Physician orders prior to dispensing them into the individual client's medication box. Any discrepancies are to be reported immediately to the Residential Nurse immediately. In turn, these discrepancies are reported by the Residential Nurse to the pharmacy 4. The Residential Nurse personally meets with the Family Physician quarterly to review the Physician order sheets & to make any corrections. These quarterly reviews are given to the pharmacy to update their records. | 09/01/2013 | | | |

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| | <p>under 70. A review of the Physician Orders (PO) dated 2/13, 3/13, 4/13, 5/13, 6/13 and 7/1/13 to 7/31/13 indicated: "Amlodipine Besylate 5 mg tablet... 1 tablet twice daily." The PO did not indicate directions to with hold client #1's medication.</p> <p>An interview with the facility's Registered Nurse (RN) was conducted on 7/26/13 at 3:15 P.M.. When asked who checked the MAR, PO and medication packages to ensure the directives for administration matched, the RN stated "Our nurse does." When asked if client #1's Amlodipine Besylate 5 mg tablet should have been with held if the diastolic reading was under 70, the RN stated "Yes, the pharmacy forgot to put it on the MAR and we overlooked the directions were not on the label, MAR and PO."</p> <p>9-3-6(a)</p> | | <p>5. The pharmacist visits the Tradewinds nursing office quarterly & audits the medications for all clients. The group home manager is responsible to monitor staff to ensure that they are following the physician's order & that the proper procedure is being followed accordingly. The Residential Nurse is responsible for ensuring that all labels on all medications are correct & correspond with the physician's order & MAR sheet.</p> | | | | |

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| W000436 | <p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>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.</p> <p>Based on observation, record review and interview, for 1 of 4 sampled clients, (client #1), the facility failed to teach and encourage the use of his prescribed eyeglasses and hearing aids.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 7/19/13 from 6:00 A.M. until 7:00 A.M.. During the entire observation period when Direct Support Professionals (DSP) #1, #2 and #3 spoke to client #1, client #1 did not respond. When DSPs #1, #2 and #3 stood in his sight and spoke to him, client #1 stated "Huh, what?" During the observation period client #1 did not wear eyeglasses and did not wear hearing aids. DSPs #1, #2 and #3 did not prompt client #1 to wear eyeglasses or hearing aids.</p> <p>An evening observation was conducted at the group on 7/22/13 from 4:20 P.M. until 6:40 P.M.. During the entire observation period when DSPs #4, #5 and #6 spoke to client #1, client #1 did not respond.</p> | W000436 | The prompting of consumer's to use their adaptive equipment has been an informal goal. However, in the future, if a consumer does have adaptive equipment, such as: glasses or hearing aids & is inconsistent with using them, a formal goal will be included in their ISP along with tracking sheets to determine the number of prompts needed for compliance. This data will also be shared with the Behavioral Specialist for possible inclusion in their behavior plan if considered necessary by the IDT. The group home manager is responsible for monitoring staff & ensuring that staff is prompting the consumer's to wear the adaptive equipment. In addition, the QDDP will observe staff during unannounced visits to the group home to ensure that staff is prompting consumers to wear adaptive equipment. | 09/01/2013 | | | |

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| | <p>When DSPs #4, #5 and #6 stood in his sight and spoke to him, client #1 stated "Huh, what?" During the observation period client #1 did not wear eyeglasses and did not wear hearing aids. DSPs #4, #5 and #6 did not prompt client #1 to wear eyeglasses or hearing aids.</p> <p>A facility owned day program observation was conducted on 7/24/13 from 11:50 A.M. until 1:00 P.M.. During the entire observation period client #1 did not wear eyeglasses or hearing aids. Day program DSP #3 did not prompt client #1 to wear his eyeglasses or hearing aids.</p> <p>A review of client #1's record was conducted on 7/24/13 at 12:42 P.M.. Review of client #1's Individual Support Plan (ISP) dated 10/29/12 indicated: "Vision Difficulties: [Client #1] has evidence of wide angle glaucoma. He also has immature cataracts bilaterally...Hearing Difficulties: [Client #1] has moderate to severe hearing loss bilaterally. Word recognition in his right ear=40% and in his left ear 36%. Amplification would be helpful if [client #1] is agreeable to wear them." Review of client #1's record indicated a most current "Audiological Evaluation" dated 7/2/13 which indicated: "Moderately to moderately severe loss bilaterally." Further review indicated client #1 was</p> | | | | | | |

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| | <p>prescribed hearing aids. Client #1's most current vision assessment dated 11/15/12 indicated he was prescribed eyeglasses.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP and the Registered Nurse (RN) was conducted on 7/26/13 at 3:14 P.M.. The RN indicated client #1 was prescribed eyeglasses and hearing aids. The RN further indicated client #1 was not cooperative with wearing his prescribed eyeglasses and hearing aids. When asked if client #1's ISP addressed his wearing his eyeglasses and hearing aids, the QIDP stated "No, it does not." When asked if client #1 should be prompted to wear his prescribed eyeglasses and hearing aids, the QIDP stated "Yes he should."</p> <p>9-3-7(a)</p> | | | |

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| NAME OF PROVIDER OR SUPPLIER TRADEWINDS SERVICES INC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 220 E GREENWOOD CROWN POINT, IN 46307 | | | |
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| W000484 | <p>483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.</p> <p>Based on observation and interview, the facility failed for 8 of 8 clients residing at the group home (clients #1, #2, #3, #4, #5, #6, #7 and #8) to provide condiments at the dining table.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 7/22/13 from 4:20 P.M. until 6:40 P.M.. At 6:20 P.M., clients #1, #2, #3, #4, #5, #6, #7 and #8 ate their evening meal which consisted of meatloaf, sliced beets, mixed vegetables, mashed potatoes, sliced bread and apple sauce. There was no salt/salt substitute, pepper, butter or ketchup on the table for clients #1, #2, #3, #4, #5, #6, #7 and #8 to use for their evening meal.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 7/26/13 at 4:30 P.M.. The QIDP indicated condiments should be put on the table for the clients to use.</p> <p>9-3-8(a)</p> | W000484 | <p>On 8/30/13, all staff at the Greenwood Group Home received re-training on the Dining Areas & Services at the group home. The group home manager is responsible for monitoring staff to ensure that condiments are available on the table during meal time. The QDDP will also observe staff during unannounced visits to the group home to ensure that condiments are available on the table during mealtime. This includes, but not limited to: salt, pepper, mustard, mayo, jelly, butter, sugar substitutes & etc. The group home manager & QDDP will conduct home visits during meal times to ensure that this is properly implemented in the home.</p> | 09/01/2013 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G171 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 08/02/2013 | |
|---|--|---|---|---|--|---|--|
| NAME OF PROVIDER OR SUPPLIER TRADEWINDS SERVICES INC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 220 E GREENWOOD CROWN POINT, IN 46307 | | | |
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| W000488 | <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation and interview, the facility failed to assure 4 of 4 sampled clients and 4 additional clients (clients #1, #2, #3, #4, #5, #6, #7 and #8) were involved in meal preparation.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 7/22/13 from 4:20 P.M. until 6:40 P.M.. During the observation period, clients #1, #2, #3, #4, #6, #7 and #8 sat in the living/dining room watching television. At 5:00 P.M., Direct Support Professional (DSP) #5 cooked the evening meal which consisted of meat loaf, sliced beets, mashed potatoes, mixed vegetables, sliced bread and apple sauce. At 6:20 P.M., clients #1, #2, #3, #4, #5, #6, #7 and #8 ate their evening meal independently. Clients #1, #2, #3, #4, #5, #6, #7 and #8 did not assist in meal preparation.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 7/26/13 at 4:30 P.M.. The QIDP indicated clients were capable of assisting in meal preparation and further indicated they should be</p> | W000488 | On 8/30/13, all staff at the Greenwood Group Home received re-training on the Dining Areas & Services at the group home. The group home manager is responsible for monitoring staff to ensure that the consumers are involved in the meal preparations. In addition, the QDDP will also observe staff during unannounced visits to the group home to ensure that the consumers are involved in the meal preparations & serving the meals according to their level of functioning. | 09/01/2013 | | | |

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| | <p>assisting in meal preparation at all times.</p> <p>9-3-8(a)</p> | | | | |