

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 10/11/2013
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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 a post certification revisit to an extended recertification and state licensure survey completed on August 2, 2013.</p> <p>Dates of Survey: October 3, 4, and 11, 2013</p> <p>Facility number: 000705 Provider number: 15G171 AIM number: 100248690</p> <p>Surveyor: Christine Colon, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed October 28, 2013 by Dotty Walton, 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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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 10/4/13 at 1:40 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	<p>All staff was trained on the Protection of Client Rights. The</p> <p>QDDP retrained staff on client rights & the client rights on decision</p> <p>making, such as: medical & decision makings. The ISP for client #1 has been</p>	11/01/2013

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	<p>learn where my 9 P.M. cream (Ketoconazole 2%) is applied." Further review of client #1's record indicated his diagnoses included, but were not limited to: Coronary Artery Disease, Congestive Heart Failure (CHF), Cardiac Arrhythmia, Hypertension, GERD (Gastroesophageal reflux disease), Mood Disorder, Dimensia (sic), 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 10/4/13 at 2:00 P.M.. The QIDP indicated client #1 did</p>		<p>updated to reflect client #1 is an emancipated adult. The group home manager is</p> <p>responsible for monitoring & ensuring that the staff following the rights</p> <p>of the consumers. In addition, the QDDP will observe during unannounced visits</p> <p>that the staff is following the rights of the consumers.</p> <p>On 11/1/13, the Residential Coordinator contacted the</p>	

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	<p>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>This deficiency was cited on 8/2/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>		<p>Director of NIAGS for guardianship for Client #1. The NIAGS Client Intake Form</p> <p>& the Physician's Report (requested documents) for Client #1 was emailed to</p> <p>the Director of NIAGS for the process of guardianship on: 12/10/13. (Please see</p> <p>attached documents).</p>		

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W000130	<p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>Based on observation and interview, the facility failed for 1 of 4 sampled clients and 2 additional client (clients #2, #6 and #7) to provide window coverings in their bedrooms, to ensure privacy.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 10/4/13 from 5:40 A.M. until 7:45 A.M. At 5:35 A.M., upon driving to the group home, client #6's bedroom was observed with no window coverings and client #6 was observed from outside his bedroom window with no clothes on dressing in his bedroom. The bedroom window next to client #6's bedroom was observed with no window coverings. At 5:40 A.M., upon entering into the group home, Direct Support Professional (DSP) #1 was asked whose bedrooms were without window coverings, DSP #1 stated "I don't know." This surveyor and DSP #1 walked to the bedrooms and DSP #1 indicated the bedrooms were those of clients #2, #6 and #7. When asked if the clients should have window coverings to ensure privacy, DSP #1 stated "Yes." When asked how long</p>	W000130	All staff was trained on the	11/01/2013

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	<p>the window coverings were missing, DSP #1 stated "I don't know."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted at the facility's administrative office on 10/4/13 at 2:00 P.M. The QIDP indicated he did not know why the bedroom blinds were taken down and further indicated all clients should have privacy while dressing in their bedrooms.</p> <p>9-3-2(a)</p>		<p>Protection of Client Rights.</p> <p>The QDDP retrained staff on client rights & the client rights on decision making, such as: medical & decision makings. . The group home manager is</p>				

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			<p>that the staff is following the rights of the consumers. The blind has been</p> <p>restored on the window of Client's #2, #6 & #7. At the time of the survey,</p>	

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			<p>the maintenance was in the process of building an extra bedroom in the home for</p> <p>Client #1. The new bedroom has been complete & the blinds have been</p>	

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			restored on the windows.	

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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 record review and interview, the facility failed for 3 of 4 sampled clients and 1 additional client (clients #1, #2, #4 and #5) to take effective corrective action for 3 of 3 reported incidents of client to client aggression.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports was conducted on 10/3/13 at 12:40 P.M.. Review of the reports indicated:</p> <p>-BDDS report dated 9/9/13 involving clients #1, #4 and #5: "On 9/9/13, the QDDP (Qualified Developmental Disabilities Professional) was informed that there was an incident on the van ride home from the day program. Staff state [client #1] was sitting behind [client #4] on the van and [client #1] tapped him in back of the head. [Client #5] saw [client #1] hit [client #4] in the back of the head and [client #5] told [client #1] to stop. [Client #1] attempted to hit [client #4] a second time. Before staff could intervene [client #5] hit [client #1] in the nose and [client #1] hit [client #5] back on the left side of the face. Staff separated the two</p>	W000157	<p>All staff at the Greenwood Group Home received training</p> <p>on the Abuse/Neglect Policy. On 8/30/2013, the staff received training on</p> <p>Client #1's Behavior Support Plan. The staff has also been trained on the</p> <p>seating arrangement when transporting consumers. This change took place due to</p>	11/01/2013			

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	<p>and redirected the two consumers... [Client #1]'s nose was bleeding and [client #5] had scratches on the side of his face that were bleeding." Further review of the report indicated "The QDDP asked [staff #13] why was he transporting (clients) alone and he stated it was a miss communication with the new house manager that was supposed to transport with him. The QDDP informed [staff #13] as well as the house manager that there will be two staff transporting at all times with no exceptions."</p> <p>-BDDS report dated 8/23/13 involving client #2: "On 8/23/13, the QDDP was informed that there was a behavior at the [Group Home name]. Staff stated that [client #2] was making noises while in the living room. [Client #5] became irritated by the noise [client #2] was making. [Client #5] walked up to [client #2] and said, 'Why don't you shut up'. (sic) Before staff could intervene, [client #5] pushed [client #2] down into the recliner. Staff was able (sic) separate the two consumers. Both consumers were assessed by staff checking for any injuries. [Client #2] had a small scratch on his left hand that did not require any medical attention."</p> <p>-BDDS report dated 8/13/13 involving client #1: "On August 14, 2013 [client</p>		<p>the behavior of Client #1. An</p> <p>investigative form has been implemented to ensure proper thorough</p> <p>investigations are completed; the effective date is: 1/3/14. The group home</p> <p>manager is responsible for monitoring & ensuring that the staff following</p> <p>the rights of the consumers. In addition, the QDDP will observe during</p>	

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	<p>#1] was sitting at the table participating in an activity with his peers. [Day program client] became upset and began to cry. When asked why she was crying she did not respond and went to [client #1] and hit [client #1] on his right shoulder. [Client #1] attempted to retaliate but staff blocked his attempt."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted at the facility's administrative office on 10/4/13 at 2:00 P.M. When asked if the Interdisciplinary 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 aggressions, the QIDP stated "No." The QIDP indicated there was no documentation available to indicate the facility took effective corrective action to address each of these incidents involving clients #1, #2, #4 and #5.</p> <p>This deficiency was cited on 8/2/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>		<p>unannounced visits that the staff is following the rights of the consumers.</p> <p>There has been a revised/updated Investigation Form completed, effective 1/3/14</p> <p>that will be utilized for all investigations. (Please see attached document).</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 observation, record review and interview the facility failed for 1 of 4 sampled clients (client #4), to ensure staff were sufficiently trained to implement client #4's "Diabetic Management Plan."</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 10/4/13 from 5:40 A.M. until 7:45 A.M. At 6:40 A.M., Direct Support Professional/DSP #1 tested client #4's blood glucose level (BGL) which tested at 49 and then administered 10 units of Levemir Flexpen (insulin). Review of the Medication Administration Record (MAR) dated 10/1/13 to 10/31/13 at 6:45 A.M. indicated: "Levemir Flexpen...10 units with breakfast...Humalog Kwikpen...inject 6 units at breakfast." Review of client #4's Physician Orders (PO) dated 10/13 indicated: "Levemir Flexpen...10 units with breakfast...Humalog Kwikpen...inject 6 units at breakfast." DSP #1 did not administer client #4's Humalog insulin. At 6:45 A.M., DSP #1 gave client #4 an 8</p>	W000189	<p>The following is Tradewinds policy for distribution of</p> <p>monthly medications:</p> <p>1.</p>	11/01/2013
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	<p>ounce serving of orange juice. When DSP #1 was asked why she did not inject client #4's Humalog insulin she stated "His reading was 49." At 7:00 A.M., DSP #1 called the Registered Nurse (RN) and notified her of client #4's BGL of 49. DSP #1 did not and was not directed to administer glucose to client #4.</p> <p>A review of client #4's record was conducted at the group home on 10/4/13 at 6:55 A.M.. Review of client #4's record indicated a "Diabetes Management Plan" no date noted, which indicated: "...Staff will notify the nurse immediately for any of the foregoing reasons: Blood sugar is under 60 Blood sugar is over 300 Body temperature over 100.5 A sore on any part of the body Nausea or vomiting. If blood sugar is 50 or under staff is to give instant glucose, either gel or liquid immediately and then call the nurse. The administration of instant glucose must be documented on the MAR sheet." Review of client #4's "Diabetes Management Plan" did not indicate to with-hold his Humalog insulin if his BGL was below a certain reading and did not indicate to call the nurse before administering his prescribed insulin.</p> <p>An interview with DSP #1 was conducted</p>		<p>Medications are prepared by the pharmacy by unit dose & are picked up by</p> <p>the Residential Nurse along with an MAR sheet & Physician order sheet for</p> <p>each client.</p> <p>2.</p> <p>The Residential Nurse must check all medications prior to their delivery to</p>				

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	<p>at the group home on 10/4/13 at 7:05 A.M. When asked if she should follow client #4's diabetic risk plan, DSP #1 stated "Yes." When asked if she should have given client #4 glucose, DSP #1 stated "Yes, because his reading was under 50." When asked if she gave client #4 glucose, she stated "No, I did not."</p> <p>An interview with the facility's Registered Nurse (RN) was conducted on 10/4/13 at 12:15 P.M. When asked if DSP #1 should have followed client #4's diabetic risk plan, the RN stated "Yes." When asked if DSP #1 should have administered glucose to client #4, the RN stated "Yes."</p> <p>This deficiency was cited on 8/2/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-3(a)</p>		<p>homes. This includes matching the physician order to the medication & MAR</p> <p>sheet. The Residential Nurse will correct any errors prior to the delivery of</p> <p>medications.</p> <p>3.</p> <p>Medications, MAR sheets & Physician order sheets are then delivered to the</p>				

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			<p>homes, where the designated staff again checks the medication label to the MAR</p> <p>sheet & Physician orders prior to dispensing them into the individual</p> <p>client's medication box. Any discrepancies are to be reported immediately to</p> <p>the Residential Nurse immediately. In turn, these discrepancies are reported by</p> <p>the Residential Nurse to the pharmacy</p>	

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			<p>4.</p> <p>The Residential Nurse personally meets with the Family Physician quarterly to</p> <p>review the Physician order sheets & to make any corrections. These quarterly reviews are given to the</p> <p>pharmacy to update their records.</p> <p>5. The pharmacist visits the</p>	

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			<p>Tradewinds nursing office quarterly & audits the medications for all</p> <p>clients.</p> <p>The group home manager is responsible to monitor staff to</p>		

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			<p>ensure that they are following the physician's order & that the proper procedure</p> <p>is being followed accordingly. The Residential Nurse is responsible for</p> <p>ensuring that all labels on all medications are correct & correspond with</p> <p>the physician's order & MAR sheet.</p> <p>On 10/4/13, there was a nursing memo sent out to the</p>		

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			<p>Greenwood Group Home for Client #4 Medication for his Diabetes. There is also</p> <p>an updated Diabetes Management Plan for Client #4, dated: October 4, 2013(Please</p> <p>see attachments).</p>	

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W000268	<p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation and interview, the facility failed for 1 additional client (client #6), to promote his dignity by not ensuring he was clothed in public areas.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 10/4/13 from 5:40 A.M. until 7:45 A.M. At 6:00 A.M., client #6 was observed walking out of his bedroom with his pants down around his ankles. Client #6 walked past Direct Support Professionals #2 and #3 and was not prompted or assisted to pull his pants up. At 6:20 A.M., client #6 walked to the kitchen with his pants down around his ankles. At 7:40 A.M., client #6 was escorted out of the group home by DSP #2 with his pants around his ankles. When DSP #2 was asked if he would fall down the stairs with his pants around his ankles, DSP #1 assisted client #6 with pulling his pants up and adjusting his belt.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 10/4/13 at 2:00 P.M. The QIDP indicated staff should ensure clients' clothing fit properly and</p>	W000268	<p>All staff was trained on the Protection of Client Rights. The</p> <p>QDDP retrained staff on client rights & the client rights on decision</p> <p>making, such as: medical & decision makings. The group home manager is</p> <p>responsible for monitoring & ensuring that the staff following the rights</p>	11/01/2013			

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	further indicated client #6 should not have been walking with his pants around his ankles. 9-3-5(a)		of the consumers. In addition, the QDDP will observe during unannounced visits that the staff is following the rights of the consumers.		

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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 2 of 4 sampled clients, (clients #1 and #4), the facility's nursing services failed to, 1. reconcile doctor's orders with labels and Medication Administration Records (MAR) and, 2. failed to ensure staff implemented client #4's diabetic risk plan.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 10/4/13 from 5:40 A.M. until 7:45 A.M.. At 6:40 A.M., DSP #1 tested client #4's blood glucose level (BGL) which tested at 49 and then administered 10 units of Levemir Flexpen. Review of the Medication Administration Record (MAR) dated 10/1/13 to 10/31/13 at 6:45 A.M. indicated: "Levemir Flexpen...10 units with breakfast...Humalog Kwikpen...inject 6 units at breakfast." Review of client #4's Physician Orders (PO) dated 10/13 indicated: "Levemir Flexpen...10 units with breakfast...Humalog Kwikpen...inject 6 units at breakfast." Direct Support Professional/DSP #1 did not administer client #4's Humalog insulin. At 6:45 A.M., DSP #1 gave client #4 an 8 ounce</p>	W000331	<p>The following is Tradewinds policy for distribution of</p> <p>monthly medications:</p> <p>1.</p> <p>Medications are prepared by the pharmacy by unit dose & are</p>	11/01/2013

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	<p>serving of orange juice. When DSP #1 was asked why she did not inject client #4's Humalog insulin she stated "His reading was 49." At 7:00 A.M., DSP #1 called the Registered Nurse (RN) and notified her of client #4's BGL of 49. DSP #1 did not and was not directed to administer glucose to client #4. At 7:10 A.M. DSP #1 tested client #1's blood pressure and then administered client #1's prescribed oral medication. A review of the MAR dated 10/1/13 to 10/31/13 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 under 70. A review of the PO dated 2/13, 3/13, 4/13, 5/13, 6/13, 7/13 and 10/1/13 to 10/31/13 indicated: "Amlodipine Besylate 5 mg tablet...1 tablet twice daily." The PO did not indicate directions regarding when to withhold client #1's medication. When DSP #1 was asked if the directives to hold the medication if the diastolic reading was under 70 were on the label, MAR and PO, DSP #1 stated "No."</p> <p>A review of client #4's group home record was conducted at the group home on 10/4/13 at 6:55 A.M. Review of client</p>		<p>picked up by</p> <p>the Residential Nurse along with an MAR sheet & Physician order sheet for</p> <p>each client.</p> <p>2.</p> <p>The Residential Nurse must check all medications prior to their delivery to</p> <p>homes. This includes matching the physician order to the</p>				

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	<p>#4's record indicated a "Diabetes Management Plan" no date noted, which indicated: "...Staff will notify the nurse immediately for any of the foregoing reasons: Blood sugar is under 60 Blood sugar is over 300 Body temperature over 100.5 A sore on any part of the body Nausea or vomiting. If blood sugar is 50 or under staff is to give instant glucose, either gel or liquid immediately and then call the nurse. The administration of instant glucose must be documented on the MAR sheet." Review of client #4's "Diabetes Management Plan" did not indicate to hold his Humalog insulin if his BGL was below a certain reading and did not indicate to call the nurse before administering his prescribed insulin.</p> <p>An interview with DSP #1 was conducted at the group home on 10/4/13 at 7:05 A.M.. When asked if she should follow client #4's diabetic risk plan, DSP #1 stated "Yes." When asked if she should have given client #4 glucose, DSP #1 stated "Yes, because his reading was under 50." When asked if she gave client #4 glucose, she stated "No, I did not."</p> <p>An interview with the facility's Registered Nurse (RN) was conducted on 10/4/13 at</p>		<p>medication & MAR</p> <p>sheet. The Residential Nurse will correct any errors prior to the delivery of</p> <p>medications.</p> <p>3.</p> <p>Medications, MAR sheets & Physician order sheets are then delivered to the</p> <p>homes, where the designated staff again checks the medication</p>		

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	<p>12:15 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 DSP #1 should have administered client #4's Humalog insulin, the RN stated "No." When asked if the PO indicated to withhold client #4's Humalog insulin, the RN stated "No, it does not." When asked if there was any documentation to indicate client #4 should not receive his Humalog insulin with breakfast, the RN stated "No." When asked if client #1's Amlodipine Besylate 5 mg tablet should be withheld 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." The RN further stated "I forgot to make sure the pharmacy put the directives on the label and MAR. When asked if DSP #1 should have followed client #4's diabetic risk plan, the RN stated "Yes."</p> <p>This deficiency was cited on 8/2/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p>		<p>label to the MAR</p> <p>sheet & Physician orders prior to dispensing them into the individual</p> <p>client's medication box. Any discrepancies are to be reported immediately to</p> <p>the Residential Nurse immediately. In turn, these discrepancies are reported by</p> <p>the Residential Nurse to the pharmacy</p>				

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			<p>4.</p> <p>The Residential Nurse personally meets with the Family Physician quarterly to</p> <p>review the Physician order sheets & to make any corrections. These quarterly reviews are given to the</p> <p>pharmacy to update their records.</p> <p>5. The pharmacist visits the</p>		

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			<p>Tradewinds nursing office quarterly & audits the medications for all clients.</p> <p>The group home manager is responsible to monitor staff to ensure that they are following the physician's order & that the proper procedure</p>		

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			<p>is being followed accordingly. The Residential Nurse is responsible for</p> <p>ensuring that all labels on all medications are correct & correspond with</p> <p>the physician's order & MAR sheet.</p> <p>On 10/4/13, there was a nursing memo sent out to the</p> <p>Greenwood Group Home for</p>	

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			<p>Client #4 Medication for his Diabetes. There is also</p> <p>an updated Diabetes Management Plan for Client #4, dated: October 4, 2013(Please</p> <p>see attachments).</p>		

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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>A morning observation was conducted at the group home on 10/4/13 from 5:40 A.M. until 7:45 A.M. At 6:00 A.M., clients #1, #2, #3, #5, #6, #7 and #8 ate their morning meal which consisted of unsweetened bran cereal and an English muffin. There was no sugar/sugar substitute, butter or jelly on the table for clients #1, #2, #3, #5, #6, #7 and #8 to use for their morning meal. At 7:00 A.M., client #4 was observed eating his morning meal which consisted of oatmeal and an English muffin. There was no sugar substitute, butter or sugar free jelly available for his use.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 10/4/13 at 2:00 P.M. The QIDP indicated condiments should be put on the table for the clients</p>	W000484	<p>All staff at the Greenwood Group Home received</p> <p>re-training on the Dining Areas & Services at the group home. The group</p> <p>home manager is responsible for monitoring staff to ensure that condiments are</p> <p>available on the table during meal time. The QDDP will also observe</p>	11/01/2013

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	<p>to use.</p> <p>This deficiency was cited on 8/2/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-8(a)</p>		<p>staff</p> <p>during unannounced visits to the group home to ensure that condiments are</p> <p>available on the table during mealtime. This includes, but not limited to:</p> <p>salt, pepper, mustard, mayo, jelly, butter, sugar substitutes & etc. The</p> <p>group home manager & QDDP will conduct home visits during meal times to</p> <p>ensure that this is properly implemented in the home.</p>		

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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 10/11/2013	
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 (clients #1, #2, #3, #4), (and 3 additional clients #5, #6 and #7), were involved in meal preparation.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 10/4/13 from 5:40 A.M. until 7:45 A.M. During the observation period, clients #1, #2, #3, #4, #6 and #7 sat in the living/dining room with no activity. At 5:50 A.M., Direct Support Professional (DSP) #3 served each client's cereal into their bowls and client #8 put English muffins into the toaster. At 6:00 A.M., clients #1, #2, #3, #4, #5, #6, #7 and #8 ate their morning meal independently. Clients #1, #2, #3, #4, #5, #6 and #7 did not assist in meal preparation and did not serve themselves.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 10/4/13 at 2:00 P.M. The QIDP indicated clients were capable of assisting in meal preparation and further indicated they should be</p>	W000488	All staff at the Greenwood Group Home received	11/01/2013			

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	<p>assisting in meal preparation at all times.</p> <p>This deficiency was cited on 8/2/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-8(a)</p>		<p>re-training on the Dining Areas & Services at the group home. The group</p> <p>home manager is responsible for monitoring staff to ensure that condiments are</p>		

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			<p>available on the table during meal time. The QDDP will also observe staff</p> <p>during unannounced visits to the group home to ensure that condiments are</p>	

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			<p>available on the table during mealtime. This includes, but not limited to:</p> <p>salt, pepper, mustard, mayo, jelly, butter, sugar substitutes & etc. The</p>		

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			<p>group home manager & QDDP will conduct home visits during meal times to</p> <p>ensure that this is properly implemented in the home.</p>		

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