STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G177	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADEWINDS SERVICES INC	8416 CLINE AVE CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000000	This visit was for an annual recertification and state licensure survey. Dates of Survey: June 18, 19, 20, 25 and 27, 2014. Surveyor: Christine Colon, QIDP. Facility Number: 000711 Provider Number: 15G177 AIM Number: 100243200 These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review completed July 6, 2014 by Dotty Walton, QIDP.	W000000		
W000104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview, the governing body failed for 2 of 4 sampled clients and 1 additional client (clients #3, #4 and #6), to exercise general operating direction over the facility to ensure clients did not pay for hair cuts.	W000104	On 7/16/2014, the house manager was re-trained on theManagement of Individual Funds and Consumer Bank Record keeping. (Please see attached training documents) TradeWinds has a policy on theManagement of Individual Funds. "TradeWinds policy is to manage the funds ofeach individual for whom we are the Representative Payee in	07/18/2014

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Findings include: A financial record review was conducted on 6/25/14 at 2:15 P.M. A review of client #3's financial record indicated she paid for a haircut on 2/16/14 in the amount of $17.00. Further review of the record indicated she had not been reimbursed for the expenditure. A review of client #4's financial record indicated she paid for a haircut on 6/23/13 in the amount of $15.00, on 2/16/14 in the amount of $17.00 and on 5/4/14 in the amount of $17.00. Further review of the record indicated she had not been reimbursed for the expenditures. A review of client #6's financial record indicated she paid for a haircut on 2/16/14 in the amount of $17.00. Further review of the record indicated she had not been reimbursed for the expenditures. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/25/14 at 3:00 P.M. The QIDP indicated clients should not pay for haircuts. 9-3-1(a)		a way that ensuresthe funds are utilized to meet the individual's living expenses and dailyneeds, respect their rights to choice and to prevent any financialexploitation. (Please see attached Policies and Procedures on the Management ofIndividuals Funds). In addition, TradeWinds also has a Procedurein place for ongoing group home consumer bank record keeping. (Please seeattached procedure for ongoing group home consumer bank record keeping) The house manager is responsible for ensuring that theconsumers are not paying for personal hygiene care, such as: haircuts (wash,condition and cut) out of his/her own pockets. The house manager will ensurethat if a consumer is paying for miscellaneous, such as: hair color, theconsumer is responsible only for that portion of the bill, not the entire bill.	
W000140	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a			

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	system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview, the facility failed to maintain an accurate accounting system for 1 of 4 sampled clients (#1), and 1 additional client (#7), for whom the facility managed their personal funds' accounts. Findings include: A review of the facility's records was conducted at the administrative office on 6/25/14 at 2:15 P.M. A review of client #1 and #7's personal financial records was conducted. Review of client #1's financial records failed to indicate the facility maintained an accurate accounting system of the clients' personal finances for the months of 6/13, 7/13, 8/13, 9/13, 10/13, 11/13, 12/13, 1/14 and 2/14. There were no records of withdrawals and/or deposits of clients #1's banking accounts and no receipts of expenditures available for review. A review of client #7's "Monthly Financial Statement" for the month of 2/14 indicated a beginning balance of $8.86. On 2/4/14 the record indicated a deposit of $30.00 totaling a balance $38.86. On 2/8/14 the ledger indicated a balance of $13.86. There was no indication on the ledger of an expenditure/expenditures	W000140	TradeWinds has a policy on theManagement of Individual Funds. "TradeWinds policy is to manage the funds ofeach individual for whom we are the Representative Payee in a way that ensuresthe funds are utilized to meet the individual's living expenses and dailyneeds, respect their rights to choice and to prevent any financialexploitation. (Please see attached Policies and Procedures on the Management ofIndividuals Funds). In addition, TradeWinds also has a Procedurein place for ongoing group home consumer bank record keeping. (Please seeattached procedure for ongoing group home consumer bank record keeping) The Policies and Procedures on theManagement of Individuals Funds, Procedures for ongoing group home consumerbank recordkeeping, Monthly Financial Statement and Petty Cash AccountabilityForms have been developed and implemented to track the finances of eachconsumer. Any issues regarding consumer accounts holding balances that are"over resources" will be brought to the attention of the QDDP immediately. Acopy of the monthly ledger is to be submitted to the QDDP by the 3rdworking day of the month. The ledger is to be reconciled by the QDDP with	07/18/2014

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	totaling $25.00. The ending balance noted (6/25/14 2:15 PM) on the ledger for client #7 indicated a balance of $6.38. Review of client #7's March 2014 "Monthly Financial Statement" did not indicate a beginning carry over balance of $6.38. On 3/7/14 a deposit of $60.00 was noted and a balance of $60.00. The record did not indicate the facility maintained an accurate accounting system of client #7's personal cash kept and maintained at the group home by group home staff. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/25/14 at 3:00 P.M. The QIDP indicated the facility managed clients #1 and #7's finances and further indicated the facility was to keep an accurate account of their finances at all times. The QIDP further indicated she did not know why the documentation was not available to indicate the facility maintained an accurate accounting system of client #1's personal finances at all times. The QIDP further indicated client #7's 2/14 and 3/14 financial statements did not indicate the group home staff kept an accurate accounting of client #7's expenditures and balances. 9-3-2(a)		thebank statement and reviewed for unusual transactions. Staff members must beprepared to provide explanations for any transactions they signed off on. Acopy is to be sent to the Program Director. All new accounts will bepre-approved by the QDDP and established accounting to TradeWinds guidelines.These policies and procedures in place will provide oversight to ensure theAbuse, Neglect and Exploitation policy and policies and procedures on theManagement of Individual Clients' funds are being implemented. The policies andprocedures in place will also ensure accurate accounting systems for eachconsumer personal petty cash funds kept at the Residential Group Homemaintained. If there are any missing funds, it is theresponsibility of the staff member to immediately contact the house manager andthe QDDP. (Please see attached Monthly Financial Statement and Petty CashAccountability Forms)For all allegations of Abuse, Neglect, Exploitation,Mistreatment and Injuries of unknown origin, the investigation will startwithin 24 hours of the alleged incident. When there is an allegation of Abuse,Neglect, Exploitation, Mistreatment and Injuries of unknown origin the staffperson(s) involved will be removed immediately from the schedule	

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			pendingoutcome of the investigation. The staff person(s) involved is responsible forcompleting an internal incident report and notifying all necessary person(s),such as: House Manager, QDDP and Residential Nurse (if medical attention isneeded). The QDDP must be notified as soon as the incident is under control andthere is no further danger to either client(s) involved. The QDDP isresponsible for making all necessary incident reports to the Bureau of DevelopmentalDisabilities (BDDS) within the guidelines (within 24 hours of incident). Thegroup home manager is responsible for monitoring and ensuring that the staffsare following the rights of the consumers. In addition, the QDDP will observeduring unannounced visits that the staffs are following the rights of theconsumers. It is the policy of TradeWinds Services to ensure that all clientshave a safe environment free of aggression, exploitation, abuse, neglect andmistreatment. It is also the policy of TradeWinds to ensure the health, welfareand rights of the individual's we serve.	
W000149	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 record review and interview, for 5 of 8 clients residing at the group	W000149	TradeWinds has a policy on Abuse,Neglect, Exploitation,	07/18/2014

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	home (clients #1, #3, #4, #5 and #7), the facility neglected to implement its "Policy on Abuse and Neglect, Exploitation, Mistreatment, Violation of an Individuals Rights, and Injuries of an unknown Origin" in regards to client to client aggression, improper restraint and elopement. Findings include: A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports and investigations was conducted on 6/20/14 at 2:30 P.M. and indicated: Incident involving client #1: -BDDS report dated 8/28/13 involving client #1 and a facility owned day program client indicated: "On August 28, 2013 [Day program client #1] was rubbing her eyes. She had gestured to staff that she wanted a paper towel to blow her nose. As staff was escorting [Day program client #1] to get the paper towel [Day program client #1] slapped [Day program client #2] on the back. When returning to her table she slapped [client #1] on her left arm." Incidents involving client #3:		Mistreatment, and Protection of an Individuals' Rightsand Injury of an unknown origin. The Policy Statement states: "Violating an Individuals Rights, Abuse and orneglect or any mistreatment of any consumer who participates in a TradeWindsServices, Inc., program is strictly prohibited and will result in severedisciplinary action up to and include discharge from employment and may furtherresult in criminal prosecution. All allegations of violating an Individualsrights or abuse and neglect of consumers served and certain other incidentsdefined in this policy are to be reported and investigated in prompt andprocedurally correct manner." (Please see attached Policies and Procedures onAbuse, Neglect, Exploitation, Mistreatment, and Protection of an Individuals'Rights and Injuries of an Unknown Origin). On 5/9/2014, staff was re- trainedon the Abuse, Neglect, Exploitation, Mistreatment and Protection of anIndividual's Rights and Injury of an unknown origin policy for the incidentinvolving client #3. (Please see attached staff trainings)The staff memberinvolved in the incident with client #3 was removed from the Cline Group Homeand no longer works with client #3. On 5/9/2014, staff was re- trainedon the Abuse, Neglect, Exploitation, Mistreatment and Protection of anIndividual's Rights and Injury of an	

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	-BDDS report dated 4/28/14 of improper restraining involving client #3 indicated: "[Client #3] is a 26 year -old female with a primary diagnosis of moderate mental retardation and mood disorder. On the morning of 4/28/14 staff reported that [client #3] woke up in a bad mood. [Client #3] was further agitated due to two of her roommates talking about sports in the living room. [Client #3] asked about snacks for workshop and before staff could answer [client #3] replied 'I hate that b---h.' Then she charged at one of her staff attempting to physically aggress towards them. According to staff, staff restrained [client #3] by putting her arm behind her back. [Client #3] dropped to her knees and laid on her stomach at that time. [Client #3] got back up from the floor and kicked staff in the stomach. According to staff, she was then restrained a second time, other staff came to assist. [Client #3] was redirected and went to the restroom with another staff to wash her face. [Client #3] was assessed for injuries and it was found that [client #3] had 5 superficial scratches on the right side of her neck. [Client #3] did not have any redness or bruising on her arm. Staff asked [client #3] if she was ok, she replied that her neck hurt where the scratches were. The QIDP (Qualified Intellectual Disabilities Professional) and		unknown origin policy for the incidentinvolving client #4. The day service staff no longer has all consumersin one program area until all staff members arrive before each staff break offinto the different program areas with the consumers in that particular programarea, such as: ADAPT 1, ADAPT2 and ADAPT3. Once all consumers arrive, the dayservice staff will immediately take each consumer into their specified programareas. Client #4 is no longer in the same program area as the Day ProgramClient #13. Client #4 and the Day Program Client #13 are escorted to his/herprogram area immediately on arrival by staff with no contact. To keep client #4 protected in the day service program (ADAPT)staff will do the followings: 1.Keep them separated.Client #4 and the other consumer will not be in the same room upon arrival andthroughout the day. 1.In the morning,consumers arrive in ADAPT1. Staff in client #4's room, ADAPT 3, will transferconsumers at 7:30am when the ADAPT 3 second staff arrives. 2.Consumers are inseparate room. Client #4 is in ADAPT 3 and the other consumer is in ADAPT 2. 3.If consumer arrives atthe day program, consumer will go into ADAPT2 with staff, so there will be nointeraction between the two consumers.	

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	House Manager were called immediately. [Client #3] was assessed by the residential nurse once [client #3] was at [Facility name] for day program....Follow-Up Systemic Actions: This incident is still under investigation at this time. However, primary investigation illustrates that an improper restraint was used twice and [client #3]'s BSP (Behavior Support Plan) was not followed....After a thorough investigation it was found that staff improperly restrained [client #3] twice. The staff is still off the schedule and will be terminated effective 5/7/14 due to improper restraints being used twice." -BDDS report dated 3/21/14 involving client #3 and a facility owned day program client indicated: "As staff passed out morning snacks to the consumers in the [Day program room], [Day program client #6] wanted her peer [client #3]'s snack also. When she was told, that she could not have her peer's snack, she then got up and hit [client #3] on the top of her head....[Client #3] complained of a headache, so [client #3] was provided with an ice pack." -BDDS report dated 3/20/14 involving client #3 indicated: "On Wednesday March 19, 2014, [Day Program client #1] had becamce (sic) upset as she walked		2.If consumer is in theroom, due to staff-consumer ration, consumer will be in line of sight andwithin arm's reach at all times. To keep client #4 protected at DayServices, Residential will do the following: 1.Drop off the consumerand his house as close to 7:45am, but no earlier than 7:30am (Please seeattached memo training sheet and staff trainings) The Cline Group Home staff will continue to monitor theCline Group Home consumers closely while on the van as a result of the incidentinvolving client #'s 3, 5 & 7. For all allegations of Abuse,Neglect, Exploitation, Mistreatment and Injuries of unknown origin, theinvestigation will start within 24 hours of the alleged incident. When there isan allegation of Abuse, Neglect, Exploitation, Mistreatment and Injuries ofunknown origin the staff person(s) involved will be removed immediately fromthe schedule pending outcome of the investigation. The staff person(s) involvedis responsible for completing an internal incident report and notifying allnecessary person(s), such as: House Manager, QDDP and Residential Nurse (ifmedical attention is needed). The QDDP must be notified as soon as the incidentis under control and there is no further danger to either client(s) involved.The QDDP is responsible for making all necessary	

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	toward her quiet area. As she was passing another consumer (client #3) she hit the consumer on the upper left arm." -BDDS report dated 1/21/14 involving client #3 indicated: "On 1/21/14 at approximately 8:25 P.M., [client #3] became upset because her roommate's friend called the group home. Staff explained to [client #3] that her roommate has the right to talk on the phone and asked [client #3] to leave the medical office where her roommate was on the phone. Staff initially followed [client #3] back towards her room and was told to calm down. It appeared that [client #3] was calm. Staff went ahead and began doing paperwork in the med office and assisting consumers throughout the house. Staff heard the garage door open from inside the house, that is when staff looked out and [client #3] was running down the driveway. Staff attempted to run after [client #3] but slipped and fell in the snow. Staff injured her ankle when she fell. When staff got off the ground, [client #3] was mid way up her driveway. The other staff brought keys to staff for the Transportation van. Staff never lost sight of [client #3]. Staff had to make a right turn out of the driveway, waiting for one car to pass by. At this point, a car came and asked [client #3] if she needed help.		incident reports to the Bureauof Developmental Disabilities (BDDS) within the guidelines (within 24 hours ofincident). TradeWinds Quality Assurance/Crisis Team meets monthly to review allinternal incident reports in regards to all consumers. The QualityAssurance/Crisis Team also monitors trends for each incident. The QDDP is responsible for conducting a thoroughinvestigation, involving all staff members and consumers involved in incidentthrough written documentation. The group home manager isresponsible for monitoring and ensuring that the staffs are following therights of the consumers. In addition, the QDDP will observe during unannouncedvisits that the staffs are following the rights of the consumers. It is thepolicy of TradeWinds Services to ensure that all clients have a safeenvironment free of aggression, exploitation, abuse, neglect and mistreatment.It is also the policy of TradeWinds to ensure the health, welfare and rights ofthe individuals we serve.	

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	This was due to [client #3] (sic) in her pajamas with only house slippers on. According to [client #3] she told the driver of the car that she did need help because she was freezing. [Client #3] got into the backseat of this vehicle. At this point , staff was trying to get [client #3] to come with them but she refused. The driver of the car called the police due to wanting to make sure that [client #3] was safe and ok. So, until the police came, [client #3] stayed in the car. Staff continued to prompt [client #3] to get in the van with her. The police came along with paramedics. [Client #3] kept telling them she left her group home because she was mad and that she is freezing....The paramedics followed [client #3] back to the group home and assessed her for injuries. There were none...." -BDDS report dated 1/1/14 involving clients #3 and #4 indicated: "On 1/1/4 at approximately 6:00 P.M., [client #3] was doing her evening chores. Suddenly, staff heard [client #4] crying. Staff immediately went to [client #4]'s room where [client #4] reported that [client #3] hit her on top of her head, reportedly with an open hand. Staff immediately assessed [client #4] for injuries, there were none present. At this time, [client #3] admitted to staff that she did hit [client #4] in the head with her hand			

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	because [client #4] called her a 'b---h' and spit on her. [Client #4] denied that she called [client #3] any names or spit on her." -BDDS report dated 8/3/13 involving clients #3 and #5 indicated: "On 8/3/13 at approximately 2:50 P.M. [client #5] began accusing [client #3] of having her bra. [Client #5] went to get the bra from her room and while in the hallway [client #3] pushed [client #5] into the wall. The push caused [client #5] to scrape the right side of her head against the wall. The strike knocked off [client #5]'s glasses, breaking them. [Client #5] also has a dime sized superficial abrasion to right top of head...." Incidents involving client #4: -BDDS report dated 5/28/14 involving client #4 and a facility owned day program client indicated: "May 28, 2014 [Day program client #13] was resisting completing activities. [Day program client #13] was redirected to complete his activity. As he was going back to the table to compete his second activity, he grabbed [client #4] by the neck. Staff quickly separated them and redirected [Day program client #13] to sit down....There was a large 6 cm(centimeter) scratch on the back of			

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	[client #4]'s neck." -BDDS report dated 4/16/14 involving client #4 and [Day program client #1] indicated: "April 16, 2014 [Day Program client #1] was having a behavior and was sitting in her chair relaxing. [Day Program client #1] jumped from her chair and hit [client #4] in the middle of the back." -BDDS report dated 4/4/14 involving client #4 and [Day program client #1] indicated: "[Day program client #1] was finishing up her morning snack at Day Program. She jumped out of her chair and ran to [client #4], smacking [client #4] with a flat hand on the middle of her back." [Day program client #13] was sitting in a chair, while his peer (client #4) was sitting at a table looking through a magazine. As [Day program client #13] got up out of his chair and walked over to [client #4], he grabbed her hair. Staff immediately intervened and once he released her hair, he then grabbed her necklace and pulled it. The necklace broke from [client #4]'s neck, which left a scratch mark. The scratch mark is located at the back of the lower part of her neck." -BDDS report dated 2/26/14 involving client #4 and a facility owned day			

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	program client indicated: "[Day program client #16] was sitting at the table waiting to participate in an activity, he started yelling and hit the consumer sitting next to him [client #4]. He hit her on the upper left arm. The consumers were separated, there were no further incidents reported." -BDDS report dated 1/16/14 involving client #4 and a facility owned day program client indicated: "[Day program client #1] and [client #4] were standing next to each other during an exercise activity. After completion of the exercise activity [Day program client #1] slapped [client #4] on her back." -BDDS report dated 1/2/14 involving clients #4 and #7 indicated: "On 1/2/14 at approximately 3:20 P.M., [client #7] was getting onto the transportation van, when [client #4] called her a 'b---h' and spit on her. [Client #7] told [client #4] to stop, when [client #4]immediately called her a 'b---h' and spit on her again. [Client #7] began to automatically hit [client #4] near her eye but just barely made contact due to stopping herself from fully hitting her." -BDDS report dated 9/26/13 involving client #4 and a facility owned day program client indicated: : "September			

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	26, 2013 at 11:00 P.M. (sic) [client #4] was sitting (sic) plates on the table for lunch, [Day program client #13] grabbed her right arm. Staff had to physically remove [Day program client #13] from holding her arm. There were scratches where his nails had dug into her skin and the scratches were visible on her arm." Incident involving client #5: -BDDS report dated 9/25/13 involving clients #3, #5 and #7 indicated: "... [Client #5] was talking to her roommates about going home with her family. This made [client #3] angry, so [client #3] slapped [client #5] in the back of the head. In turn, [client #7] pushed her hands into [client #3]'s face to block her from [client #5]. While [client #7] was pushing [client #3] away, she scratched [client #3]'s right upper cheek under her eye, leaving a 1 inch scrape. There is also a 1/2 inch scrape on [client #3]'s left cheek, close to her mouth. At this time [client #3] grabbed [client #7]'s hair but then almost immediately removed her grip." A review of the facility's "Policy on Abuse, Neglect, Exploitation, Mistreatment, Violation of an Individual's Rights and Injuries of an unknown Origin" dated 3/10/09 was			

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	conducted at the facility's administrative office on 6/25/14 at 10:00 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 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...Exploitation. Financial, any deliberate misplacement, exploitation, or wrongful temporary or permanent use of an individual's belongings or money." An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/25/14 at 3:00 P.M. The QIDP indicated staff were to			

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	monitor all clients while at the group home and day program to prevent client to client aggression. The QIDP indicated staff should prevent client #3 from eloping by keeping her in eyesight. The QIDP indicated the staff was terminated for improperly restraining client #3. 9-3-2(a)			
W000249	483.440(d)(1) PROGRAM IMPLEMENTATION 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. Based on record review and interview, for 1 of 4 sampled clients (client #3), the facility failed to ensure the client's Behavior Support Plan (BSP) was	W000249	On 5/9/2014, staff were re-trained on the BSP for client #3.On 7/15/2014, the QDDP emailed the behaviorist for the Burrell Group Home to request an	07/18/2014

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	implemented as written. Findings include: A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports and investigations was conducted on 6/20/14 at 2:30 P.M. and indicated: -BDDS report dated 1/21/14 involving client #3 indicated: "On 1/21/14 at approximately 8:25 P.M., [client #3] became upset because her roommate's friend called the group home. Staff explained to [client #3] that her roommate has the right to talk on the phone and asked [client #3] to leave the medical office where her roommate was on the phone. Staff initially followed [client #3] back towards her room and was told to calm down. It appeared that [client #3] was calm. Staff went ahead and began doing paperwork in the med office and assisting consumers throughout the house. Staff heard the garage door open from inside the house, that is when staff looked out and [client #3] was running down the driveway. Staff attempted to run after [client #3] but slipped and fell in the snow. Staff injured her ankle when she fell. When staff got off the ground, [client #3] was mid way up her driveway. The other		update/revision made to the BSPs for the Burrell Group Home that will give a thorough indication of what is least restrictive to most restrictive measures during a behavior that involves a hold/restraint. A thorough description of the holds to be utilized by staff must be thoroughly listed in the BSP for each consumer to guide staff to ensure proper implementation. The QDDP is responsible for ensuring that the BSPs have thorough descriptions of various holds to utilize (for least restrictive to most effective measures) during a behavior in the BSP for staff guidance to ensure proper implementation for each consumer in his/her BSP (client specific). A new behavioral provider has been selected for the Cline Group Home The New Behaviorist has reviewed all old Behavior Support Plans for the Cline Group Home consumers and is in the process of updating all plans to include the least restrictive to most effective measures. The QIDP will continue to communicate on a weekly basis with new behavior specialist to ensure compliance with consumer specific restraints are very descriptive (for least restrictive to most effective measures) that will give staff specific instructions on proper restraint to use per consumer's BSP. In addition, the Residential Coordinator will follow up with the	

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	staff brought keys to staff for the Transportation van. Staff never lost sight of [client #3]. Staff had to make a right turn out of the driveway, waiting for one car to pass by. At this point, a car came and asked [client #3] if she needed help. This was due to [client #3] in her pajamas with only house slippers on. According to [client #3] she told the driver of the car that she did need help because she was freezing. [Client #3] got into the backseat of this vehicle. At this point, staff was trying to get [client #3] to come with them but she refused. The driver of the car called the police due to wanting to make sure that [client #3] was safe and ok. So, until the police came, [client #3] stayed in the car. Staff continued to prompt [client #3] to get in the van with her. The police came along with paramedics. [Client #3] kept telling them she left her group home because she was mad and that she is freezing....The paramedics followed [client #3] back to the group home and assessed her for injuries. There were none....." A review of client #3's record was conducted on 6/20/14 at 1:15 P.M. Review of client #1's BSP dated 1/1/14 indicated: "Elopement: Exiting the house or designated area and/or leaving the property without supervision or permission from staff...[Client #3] should		communication between the QIDP and behaviorist to monitor and to ensure compliance. The house manager is responsible for observing the grouphomes and making sure all items that are needed are in the home at least 5 days a week. TheQIDP will observe during weekly unannounced visits that the group home has allitems that are needed and to ensure that all items are working properly andefficiently. **A residential QIDP weeklysite visit checklist has been developed as an onsite monitoring system, effective August 5, 2014 and will be utilizedby the QIDP's on the weekly visits. (Please see attached weekly checklist) The weekly checklist will be turned into theresidential coordinator on a weekly basis for additional auditing for the grouphome.** In addition to the house managers and QIDPs visits to the group homes, the residentialcoordinator will conduct monthly unannounced visits to the group homes.	

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	be closely monitored at all times." An interview with the Qualified Intellectual Disability Professional (QIDP) was conducted on 6/25/14 at 3:00 P.M. The QIDP indicated staff should monitor client #3 closely at all times as written in her BSP to prevent her from eloping. 9-3-4(a)			
W000289	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. Based on record review and interview, for 1 of 4 sampled clients (clients #3), the facility failed to ensure systematic interventions (physical holds) in the Behavior Support Plans (BSP) were specifically written/described. Findings include: A review of the facility's Bureau of Developmental Disabilities Services	W000289	On 7/15/2014, the QDDP emailed the behaviorist for the ClineGroup Home to request an update/revision made to the BSPs for the Cline GroupHome that will give a thorough indication of what is least restrictive to mostrestrictive measures during a behavior that involves a hold/restraint. (Please see attached email) Athorough description of the holds to be utilized by staff must be	07/18/2014

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	(BDDS) reports and investigations was conducted on 6/20/14 at 2:30 P.M. and indicated: -BDDS report dated 4/28/14 of improper restraining involving client #3 indicated: "[Client #3] is a 26 year -old female with a primary diagnosis of moderate mental retardation and mood disorder. On the morning of 4/28/14 staff reported that [client #3] woke up in a bad mood. [Client #3] was further agitated due to two of her roommates talking about sports in the living room. [Client #3] asked about snacks for workshop and before staff could answer [client #3] replied 'I hate that b---h.' Then she charged at one of her staff attempting to physically aggress towards them. According to staff, staff restrained [client #3] by putting her arm behind her back. [Client #3] dropped to her knees and laid on her stomach at that time. [Client #3] got back up from the floor and kicked staff in the stomach. According to staff, she was then restrained a second time, other staff came to assist. [Client #3] was redirected and went to the restroom with another staff to wash her face. [Client #3] was assessed for injuries and it was found that [client #3] had 5 superficial scratches on the right side of her neck. [Client #3] did not have any redness or bruising on her arm. Staff		thoroughlylisted in the BSP for each consumer to guide staff to ensure properimplementation. The QDDP is responsible for ensuring that the BSPs havethorough descriptions of various holds to utilize (for least restrictive tomost effective measures) during a behavior in the BSP for staff guidance toensure proper implementation for each consumer in his/her BSP (clientspecific). The Cline Group Home consumers will be working with a newbehaviorist from another agency.	

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	asked [client #3] if she was ok, she replied that her neck hurt where the scratches were. The QIDP (Qualified Intellectual Disabilities Professional) and House Manager were called immediately. [Client #3] was assessed by the residential nurse once [client #3] was at [Facility name] for day program....Follow-Up Systemic Actions: This incident is still under investigation at this time. However, primary investigation illustrates that an improper restraint was used twice and [client #3]'s BSP (Behavior Support Plan) was not followed....After a thorough investigation it was found that staff improperly restrained [client #3] twice. The staff is still off the schedule and will be terminated effective 5/7/13 due to improper restraints being used twice." Further review of the report failed to indicate what type of restraint/hold staff used for client #3. -BDDS report dated 9/4/13 involving client #3 indicated: "On 9/4/13 [client #8] told staff that [client #3] said her hair was ugly. Staff then asked [client #8] to come into the living room where there was another staff sitting with [client #3]. [Client #3] jumped up when [client #8] came in the living room, but quickly sat back down when asked by staff. Suddenly, [client #3] jumped back up and			

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	tried to angrily come towards towards (sic) [client #8] which staff was standing in front of at the time. Staff stood directly in front of [client #3] in order to block her from [client #8]. [Client #3] pushed staff. Due to [client #3] becoming physically and verbally aggressive, staff had to put [client #3] in a restraint. The restraint was held for less than one minute until she calmed down. [Client #3] calmed down very quickly and got ready to leave for the workshop...The restraint used by staff is in accordance to [client #3's] Behavior Support Plan (BSP)." Further review of the report failed to indicate what type of restraint/hold staff used for client #3. A review of client #3's record was conducted on 6/20/14 at 1:15 P.M. Review of client #1's BSP dated 1/1/14 indicated: "If physical aggression escalates to the point that she is a risk to herself or others, the least restrictive but most effective procedures of physical intervention should be used." Further review of the BSP did not indicate nor describe what the least restrictive but most effective hold should be implemented when client #3 is a risk to herself or to others. An interview with the Qualified Intellectual Disability Professional			

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	(QIDP) was conducted on 6/25/14 at 3:00 P.M. The QIDP indicated client #1's BSPs did not indicate how the holds/techniques would be implemented when needed. The QIDP further indicated they did not have the description of the holds to be used in the BSP for staff guidance to ensure proper implementation. 9-3-5(a)			