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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G171 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>01/03/2014 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>TRADEWINDS SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE<br>220 E GREENWOOD<br>CROWN POINT, IN 46307 |
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| W000000            | <p>This visit was for the investigation of Complaint #IN00139934.</p> <p>COMPLAINT #IN00139934: Substantiated, federal/state deficiencies related to the allegations are cited at W149 and W154.</p> <p>Dates of Survey: 12/16/13 and 1/3/2014.</p> <p>Facility number: 000705<br/>Provider number: 15G171<br/>AIM number: 100248690</p> <p>Surveyor:<br/>Amber Bloss, QIDP</p> <p>The following deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 1/13/14 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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| W000149   | <p>483.420(d)(1)<br/>STAFF TREATMENT OF CLIENTS<br/>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on record review and interview for 3 of 3 sampled clients (A, B and C), the facility failed to implement its policy and procedures to thoroughly investigate 2 of 3 investigations reviewed for injuries during restraints for 1 of 3 sampled clients (A) and 1 of 2 investigations reviewed for client to client abuse for 3 of 3 sampled clients (A, B, and C).</p> <p>Findings include:</p> <p>1) On 12/16/13 at 3:31 PM, the facility BDDS (Bureau of Developmental Disabilities Services) reports from 8/1/13 to 12/16/13 and related investigations were reviewed and indicated the following:</p> <p>-A BDDS report dated 9/1/13 indicated Client A "was in behavior. [Client A] walked in the medication room and attempted to go thought (sic) the medications. Also [Client A] was picking up the telephone and dialing numbers of people he did not know. When staff attempted to redirected (sic) [Client A], he became verbally and physically aggressive. Staff had to restrain [Client A] using a two staff arm hold to direct him out of the medication room." The report indicated "the restraint used by staff is in accordance to [Client A]'s BSP (Behavior Support Plan)." The report indicated "no injuries as a result of this incident."</p> <p>The investigation packet dated 9/1/13 included the internal incident report dated 9/1/13. The internal report indicated scratches were sustained</p> | W000149   | <p>On Wednesday, January 15, 2014, all staffs were trained on Incident Reporting, such as: what is reportable, the protocol for whom to contact to notify about the incident and the correct way to fill out an incident report form (Please see attached documents). Staff will continue to receive ongoing trainings on Incident Reporting.</p> <p>On Friday, January 24, 2014, the Greenwood staff were trained on the followings: Abuse and Neglect policy, when to use restraints and how it should be done, how to utilize and follow BSPs, Client Rights, transporting</p> | 01/24/2014  |  |   |  |

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|                    | <p>on the right hand and left breast area but did not specify if the scratches were sustained by staff or Client A. The investigation summary written by the QIDP and dated 9/1/13 indicated DSP (Direct Support Professional) #2 "stated to the [QIDP] during her shift [Client A] consumer had to be restrained. [DSP #2] stated [Client A] was verbally redirected several times. [DSP #2] stated [Client A] was using the house phone and dialing numbers of people that he did not know. Staff stated while trying to redirect [Client A] he became verbally and physically aggressive. [DSP #2] stated as a last result they had to retrain (sic) [Client A]." The investigation indicated DSP #3 was present during the restraint. The report indicated DSP #3 "stated [Client A] hit staff and attempted to throw his walker." The report indicated DSP #3 "stated as a last result (sic) they had to retrain (sic) [Client A]."</p> <p>The investigation failed to include interviews with clients and/or other potential witnesses. The investigation failed to indicate whether Client A was injured. The investigation failed to indicate whether Client A's BSP was followed correctly.</p> <p>-A BDDS report dated 9/23/13 indicated the QIDP (Qualified Intellectual Disabilities Professional) "was informed [Client A] had a behavior on 9/22/13. Staff stated they assisted [Client A] with contacting his niece on the phone. After [Client A] was unable to get in contact with his family he became verbally and physically aggressive with staff. [Client A] hit two staff members while displaying his behavior. Staff had to restrain [Client A] using a two staff arm hold." The report indicated Client A "was able to be redirected in accordance to his BSP (Behavior Support Plan)." The report indicated "the restraint used on [Client A] is in accordance</p> |               | <p>the consumers on the van with 2 staff members (at all times), seating</p> <p>arrangements on the van (while transporting) and while at the dinner table to</p> <p>help prevent client on client aggressions (Please see attached documents). Staff</p> <p>members will continue to receive ongoing trainings on the following areas:</p> <p>Abuse, Neglect, BSPs, when to use a restraint, utilizing the least restrictive</p> <p>measures and exhausting all possibilities prior to restraining, Client Rights</p> <p>and how to prevent client on client aggressions.</p> <p>For all investigation in regards of the followings:</p> <p>abuse, neglect, Injuries of unknown origin, client on client aggression,</p> <p>medication error, fall, complaint,</p> |                      |

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|                    | <p>to his BSP. There were no injuries as a result of this incident."</p> <p>The investigative packet dated 9/22/13 contained an internal incident report dated 9/22/13 and was written by DSP (Direct Support Professional) #1. In the report, DSP #1 stated "I was cleaning off table getting ready for the men to eat breakfast. We was (sic) setting up for breakfast. The phone and spray was (sic) on the table. I remove (sic) spray and phone. [Client A] hit me in my arm." The incident report indicated Client A became verbally aggressive toward DSP #1. The report indicated Client A "had to get restrain (sic) by staff. [Client A] now complaining about his left hand across the middle."</p> <p>The investigative summary written by the QIDP (dated 9/22/13) indicated DSP #1 reported "she was hit in the arm by [Client A]." The summary report indicated DSP #1 indicated Client A hit her "because I moved the phone." The report indicated "staff stated prior to the behavior staff attempted to help [Client A] contact his niece on the phone but was unsuccessful. [DSP #1] stated [Client A] wanted to continue to contact his niece and staff redirected [Client A] to try later. [DSP #1] stated when she moved the phone off the table to set up the table [Client A] began hitting her. As a result she (DSP #1) had to restrain him. [DSP #1] stated the restraint use was in accordance to [Client A]'s BSP." The investigation failed to include other potential witness statements. The investigation failed to indicate whether Client A sustained an injury to his hand.</p> <p>On 12/16/13 at 4:20 PM, record review indicated Client A's diagnoses included, but were not limited to, intellectual disabilities, neurogenic bladder (incontinence), mood</p> |               | <p>accident (auto), violation of consumer rights and others. The investigations will start within 24 hours of the alleged incident. When there is an allegation of abuse, neglect and or exploitation, the staff person(s) involved will be removed immediately from schedule pending outcome of investigation. The staff person(s) involved is responsible for completing an internal incident report and to notify all necessary person(s), such as: House Manager, QDDP and Residential Nurse.</p> <p>The QDDP must be notified as soon as the incident is under control and there is no further danger to client(s) involved. The QDDP is responsible for making all necessary</p> |                      |

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|   | <p>disorder, pancreatitis, pacemaker, glaucoma, and dementia.</p> <p>Client A's ISP (Individual Support Plan) dated 10/29/13 indicated Client A had a BSP (Behavior Support Plan) dated 7/01/13. Client A's BSP indicated targeted behaviors of verbal aggression, physical aggression, inappropriate attention seeking, noncompliance, and wandering. Client A's BSP defined physical aggression as "the use of physical force directed towards another person that has the potential to result in injury." Client A's BSP indicated Client A's "behaviors serve an attention function, therefore staff should limit the amount of attention (even negative) that [Client A] receives in order to avoid reinforcing them." The BSP indicated Client A "has a tendency to have long and intense behaviors, staff should be aware that it may take longer to gain compliance with [Client A]." The BSP indicated "staff should be mindful of their tone of voice when redirecting [Client A] especially during behavior episodes. Caregiver's tone of voice should be non-emotional and direct. Staff should respond in a calm, nonthreatening manner and under no circumstances should staff/caregivers engage in an argument or power struggle with [Client A]." Client A's BSP indicated "[Client A] has a history of escalating to physical aggression during other problem behaviors. Caregivers should always remain an arm's length distance away from [Client A] during periods of agitation, or keep body posture turned from [Client A] while keeping one arm free for blocking if necessary." Client A's BSP indicated a procedure for staff to follow when Client A began to appear agitated and became verbally aggressive which included verbally prompting Client A to use coping skills, withdraw attention, and a "time-out" procedure. Client A's BSP</p> |   | <p>incident reports to the Bureau of Developmental Disabilities (BDDS) within the guidelines (within 24 hours of the incident). Once the BDDS report is completed by the QDDP an investigation will start within 24 hours of the alleged incident.</p> <p>After a thorough investigation, prompt and necessary changes will occur. The Residential Coordinator and or Program Director will review the investigation findings and will sign off with a final review.</p> <p>In addition, Tradewinds Crisis Team meets monthly to review all internal incident reports in regards to all consumers. The Crisis Team also monitors trends for each incident. During the Crisis Team meetings, the team discusses if the consumer(s) have a history of this behavior(s), if the consumer have a behavior support plan, if so, does the</p> |   |  |   |  |

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|   | <p>indicated a procedure for physical aggression. The BSP indicated staff should "prompt him to make an appropriate verbal request or to use another coping skill." The BSP indicated "if [Client A] becomes physically aggressive, staff should use their forearm to block him (sic) attempts to strike or they should move their bodies to avoid a kick." The BSP indicated "at this point [Client A] will not earn his reward for the given time period." The BSP indicated "if instigating other and/or [Client A] is not able to calm down after 2 minutes; staff should escort him to time-out: designated area away from peers (day program)/bedroom (home)." Client A's BSP indicated "once in time-out staff should direct him to continue the task requested prior to physical aggression or have him engage in an activity." The BSP indicated "if physical aggression escalates to the point that he is a risk to himself or others, the least restrictive but more effective procedures of physical intervention should be utilized." Client A's BSP indicated "a time-out procedure is also included in this plan if physical and/or verbal aggression persists for longer than 2 minutes. Also included within this procedure is the possibility of an escort into the time out location." The BSP indicated "if [Client A]'s behavior escalates to the point where he is at risk of harming himself or others, the least restrictive, but most effective form of physical intervention should be utilized only after blocking procedures have proved ineffective."</p> <p>On 12/16/13 at 4:20 PM during an interview with the facility nurse and QIDP (Qualified Intellectual Disabilities Professional), the QIDP indicated the facility reports all restraints to BDDS. The QIDP indicated he did not know whether all elements of Client A's BSP were attempted prior to Client A's restraints. The</p> |   | <p>plan work, if not, should the consumer be referred to a behaviorist for</p> <p>behavioral services, if the behaviorist was notified, what were the</p> <p>recommendations, has there been a team meeting to discuss the incident further,</p> <p>if the consumer has a psychiatrist, if so has the psychiatrist been notified,</p> <p>has there been any changes with the medications, were the proper actions taken,</p> <p>was staff suspended and or terminated, was the protocol followed, was the</p> <p>incident a result of staff or another consumer and or should additional</p> <p>action(s) be taken. An additional follow</p> <p>up is completed after the monthly Crisis meetings. It is the policy of</p> <p>Tradewinds Services to ensure that all clients have a safe environment free of</p> <p>aggression from all sources including client on client aggression. It is also</p> |   |  |   |  |

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|                    | <p>QIDP indicated he interviewed staff and asked whether Client A's BSP was followed to which the staff in each instance replied, "Yes." The facility nurse and QIDP indicated they were unsure who sustained the scratches reported on the 9/1/13 internal incident report, whether staff sustained the injury or Client A. The facility nurse indicated she had no record of Client A's complaint of his hand hurting following the restraint on 9/22/13 and had no documentation of follow up. The QIDP indicated he agreed the facility should have ensured Client A's BSP was followed to ensure restraints were being implemented correctly. The QIDP and facility nurse indicated if restraints were done correctly, no injury should have occurred.</p> <p>2) On 12/16/13 at 3:31 PM, the facility BDDS (Bureau of Developmental Disabilities Services) reports from 8/1/13 to 12/16/13 and related investigations were reviewed and indicated the following:</p> <p>-A BDDS report dated 9/10/13 indicated "staff state (sic) [Client A] was sitting behind [Client B] on the van and [Client A] tapped him in back of the head. [Client C] saw [Client A] hit [Client B] in the back of the head and [Client C] told [Client A] to stop." The report indicated Client A "attempted to hit [Client B] a second time. Before staff could intervene [Client C] hit [Client A] in the nose and [Client A] hit [Client C] back on the left side of the face. Staff separated the two and redirected the two consumers." The report indicated the nurse assessed the clients involved for injury and indicated Client A's "nose was bleeding and [Client C] had scratches on the side of his face that were bleeding." The report indicated Client B did not sustain any injuries as a result of the incident.</p> |               | <p>the policy of Tradewinds to ensure the health, welfare &amp; rights of the</p> <p>individuals we serve.</p>  |                      |

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|  | <p>The investigation packet dated 9/9/13 indicated "on 9/9/13, DSP (Direct Support Professional) #4 reported "there was a behavior on the van ride home from the day program." The investigation indicated "[DSP #4] stated he was pulling over the van as [Client C] and [Client A] were exchange (sic) hits." The report indicated the QIDP (Qualified Intellectual Disabilities Professional) asked DSP #4 "why he was transporting alone and he stated it was a miss (sic) communication with the new house manager that was supposed to transport with him." The investigation packet indicated the QIDP "informed [DSP #4] as well as the House Manager that there will be two staff transporting at all times with no exceptions."</p> <p>On 12/16/13 at 4:20 PM during an interview, the QIDP (Qualified Intellectual Disabilities Professional) indicated the incident was not investigated thoroughly. The QIDP indicated DSP #4 should not have been transporting alone during the incident on 9/9/13.</p> <p>On 12/16/13 at 2:48 PM, the facility policy on "Abuse, Neglect, Exploitation, Mistreatment, Violation of an Individuals Rights, and Injuries of Unknown Origin" dated 2/1/2011 was reviewed and indicated "Abuse and or neglect or any mistreatment of any consumer who participates in TradeWinds program is strictly prohibited...". The facility Abuse/Neglect policy indicated potential "physical abuse includes willful infliction of injury, unnecessary physical or chemical restraint...". The policy indicated "neglect includes failure to provide appropriate care, food, medical care or supervision."</p> <p>This federal tag relates to complaint #IN00139934.</p> |  |  |  |
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| W000154            | <p>9-3-2(a)</p> <p>483.420(d)(3)<br/>STAFF TREATMENT OF CLIENTS<br/>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview, the facility failed to thoroughly investigate 2 of 3 investigations reviewed for injuries in restraints for 1 of 3 sampled clients (A) and 1 of 2 investigations reviewed for client to client abuse for 3 of 3 sampled clients (A, B, and C).</p> <p>Findings include:</p> <p>1) On 12/16/13 at 3:31 PM, the facility BDDS</p> | W000154       | <p>On Wednesday, January 15, 2014, all staffs were trained on Incident Reporting, such as: what is reportable, the protocol for whom to contact to notify about the</p> | 01/24/2014           |

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|   | <p>(Bureau of Developmental Disabilities Services) reports from 8/1/13 to 12/16/13 and related investigations were reviewed and indicated the following:</p> <p>1a) -A BDDS report dated 9/1/13 indicated Client A "was in behavior. [Client A] walked in the medication room and attempted to go thought (sic) the medications. Also [Client A] was picking up the telephone and dialing numbers of people he did not know. When staff attempted to redirected (sic) [Client A], he became verbally and physically aggressive. Staff had to restrain [Client A] using a two staff arm hold to direct him out of the medication room." The report indicated "the restraint used by staff is in accordance to [Client A]'s BSP (Behavior Support Plan)." The report indicated "no injuries as a result of this incident."</p> <p>The investigation packet dated 9/1/13 included the internal incident report dated 9/1/13. The internal report indicated scratches were sustained on the right hand and left breast area but did not specify if the scratches were sustained by staff or Client A. The investigation summary written by the QIDP and dated 9/1/13 indicated DSP (Direct Support Professional) #2 "stated to the [QIDP] during her shift [Client A] consumer had to be restrained. [DSP #2] stated [Client A] was verbally redirected several times. [DSP #2] stated [Client A] was using the house phone and dialing numbers of people that he did not know. Staff stated while trying to redirect [Client A] he became verbally and physically aggressive. [DSP #2] stated as a last result they had to restrain (sic) [Client A]." The investigation indicated DSP #3 was present during the restraint. The report indicated DSP #3 "stated [Client A] hit staff and attempted to throw his walker." The report indicated DSP #3 "stated as</p> |   | <p>incident and the correct way to fill out an incident report form (Please see attached documents). Staff will continue to receive ongoing trainings on Incident Reporting.</p> <p>On Friday, January 24, 2014, the Greenwood staff were trained on the followings: Abuse and Neglect policy, when to use restraints and how it should be done, how to utilize and follow the BSPs, Client Rights, transporting the consumers on the van with 2 staff members (at all times), seating arrangements on the van (while transporting) and while at the dinner table to help prevent client on client aggressions (Please see attached</p> |                      |   |

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|   | <p>a last result (sic) they had to restrain (sic) [Client A]." The investigation failed to include interviews with clients and/or other potential witnesses. The investigation failed to indicate whether Client A was injured. The investigation failed to indicate whether each element of Client A's BSP was followed correctly.</p> <p>1b) -A BDDS report dated 9/23/13 indicated the QIDP (Qualified Intellectual Disabilities Professional) "was informed [Client A] had a behavior on 9/22/13. Staff stated they assisted [Client A] with contacting his niece on the phone. After [Client A] was unable to get in contact with his family he became verbally and physically aggressive with staff. [Client A] hit two staff members while displaying his behavior. Staff had to restrain [Client A] using a two staff arm hold." The report indicated Client A "was able to be redirected in accordance to his BSP (Behavior Support Plan)." The report indicated "the restraint used on [Client A] is in accordance to his BSP. There were no injuries as a result of this incident."</p> <p>The investigative packet dated 9/22/13 contained an internal incident report dated 9/22/13 and was written by DSP (Direct Support Professional) #1. In the report, DSP #1 stated "I was cleaning off table getting ready for the men to eat breakfast. We was (sic) setting up for breakfast. The phone and spray was (sic) on the table. I remove (sic) spray and phone. [Client A] hit me in my arm." The incident report indicated Client A became verbally aggressive toward DSP #1. The report indicated Client A "had to get restrain (sic) by staff. [Client A] now complaining about his left hand across the middle."</p> <p>The investigative summary written by the QIDP (dated 9/22/13) indicated DSP #1 reported "she</p> |   | <p>documents). Staff members will continue to receive ongoing trainings on the following</p> <p>areas: Abuse, Neglect, BSPs, when to use a restraint, utilizing the least</p> <p>restrictive measures and exhausting all possibilities prior to restraining,</p> <p>Client Rights and how to prevent client on client aggressions.</p> <p>For all investigation in regards of the followings:</p> <p>abuse, neglect, Injuries of unknown origin, client on client aggression,</p> <p>medication error, fall, complaint, accident (auto), violation of consumer</p> <p>rights and others. The investigations will start within 24 hours of the alleged</p> <p>incident. When there is an allegation of abuse, neglect and or exploitation,</p> <p>the staff person(s) involved will be</p> |   |  |   |  |

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|   | <p>was hit in the arm by [Client A]." The summary report indicated DSP #1 indicated Client A hit her "because I moved the phone." The report indicated "staff stated prior to the behavior staff attempted to help [Client A] contact his niece on the phone but was unsuccessful. [DSP #1] stated [Client A] wanted to continue to contact his niece and staff redirected [Client A] to try later. [DSP #1] stated when she moved the phone off the table to set up the table [Client A] began hitting her. As a result she (DSP #1) had to restrain him. [DSP #1] stated the restraint use was in accordance to [Client A]'s BSP." The investigation failed to include other potential witness statements. The investigation failed to indicate whether Client A sustained an injury to his hand.</p> <p>On 12/16/13 at 4:20 PM during an interview with the facility nurse and QIDP (Qualified Intellectual Disabilities Professional), the QIDP indicated he did not know whether all elements of Client A's BSP were attempted prior to Client A's restraints such as redirection to a time out area or physical blocking. The QIDP indicated he interviewed staff and asked whether Client A's BSP was followed to which the staff in each instance replied, "Yes." The QIDP indicated he did not ask further specific questions regarding the implementation of Client A's BSP. The facility nurse and QIDP indicated they were unsure who sustained the scratches reported on the 9/1/13 internal incident report, whether staff sustained the injury or Client A. The facility nurse indicated she had no record of Client A's complaint of his hand hurting following the restraint on 9/22/13 and had no documentation of follow up. The QIDP indicated he agreed the investigations were not thorough as the facility should have ensured Client A's BSP was followed accurately prior to use of restrain on</p> |   | <p>removed immediately from schedule pending</p> <p>outcome of investigation. The staff person(s) involved is responsible for</p> <p>completing an internal incident report and to notify all necessary person(s),</p> <p>such as: House Manager, QDDP and Residential Nurse.</p> <p>The QDDP must be</p> <p>notified as soon as the incident is under control and there is no further</p> <p>danger to client(s) involved. The QDDP is responsible for making all necessary</p> <p>incident reports to the Bureau of Developmental Disabilities (BDDS) within the</p> <p>guidelines (within 24 hours of the incident). Once the BDDS report is completed</p> <p>by the QDDP an investigation will start within 24 hours of the alleged</p> |   |  |   |  |

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|   | <p>Client A. The QIDP indicated the investigation should have indicated whether staff used approved methods of restraint to ensure unnecessary injury.</p> <p>2) On 12/16/13 at 3:31 PM, the facility BDDS (Bureau of Developmental Disabilities Services) reports from 8/1/13 to 12/16/13 and related investigations were reviewed. A BDDS report dated 9/10/13 indicated "staff state (sic) [Client A] was sitting behind [Client B] on the van and [Client A] tapped him in back of the head. [Client C] saw [Client A] hit [Client B] in the back of the head and [Client C] told [Client A] to stop." The report indicated Client A "attempted to hit [Client B] a second time. Before staff could intervene [Client C] hit [Client A] in the nose and [Client A] hit [Client C] back on the left side of the face. Staff separated the two and redirected the two consumers." The report indicated the nurse assessed the clients involved for injury and indicated Client A's "nose was bleeding and [Client C] had scratches on the side of his face that were bleeding." The report indicated Client B did not sustain any injuries as a result of the incident.</p> <p>The investigation packet dated 9/9/13 indicated "on 9/9/13, DSP (Direct Support Professional) #4 reported "there was a behavior on the van ride home from the day program." The investigation indicated "[DSP #4] stated he was pulling over the van as [Client C] and [Client A] were exchange (sic) hits." The report indicated the QIDP (Qualified Intellectual Disabilities Professional) asked DSP #4 "why he was transporting alone and he stated it was a miss (sic) communication with the new house manager that was supposed to transport with him." The investigation packet indicated the</p> |   | <p>incident. After a thorough investigation, prompt and necessary changes will occur. The Residential Coordinator and or Program Director will review the investigation findings and will sign off with a final review. In addition, Tradewinds Crisis Team meets monthly to review all internal incident reports in regards to all consumers.</p> <p>The Crisis Team also monitors trends for each incident. During the Crisis Team meetings, the team discusses if the consumer(s) have a history of this behavior(s), if the consumer have a behavior support plan, if so, does the plan work, if not, should the consumer be referred to a behaviorist for behavioral services, if the behaviorist was notified, what were the recommendations, has there been a team meeting to discuss the incident further, if the consumer has a psychiatrist, if so has the</p> |   |  |   |  |

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|                    | <p>QIDP "informed [DSP #4] as well as the House Manager that there will be two staff transporting at all times with no exceptions."</p> <p>On 12/16/13 at 4:20 PM during an interview, the QIDP (Qualified Intellectual Disabilities Professional) indicated the investigation was not thorough.</p> <p>This federal tag relates to complaint #IN00139934.</p> <p>9-3-2(a)</p> |               | <p>psychiatrist been notified, has there been any</p> <p>changes with the medications, were the proper actions taken, was staff</p> <p>suspended and or terminated, was the protocol followed, was the incident a</p> <p>result of staff or another consumer and or should additional action(s) be</p> <p>taken. An additional follow up is</p> <p>completed after the monthly Crisis meetings. It is the policy of Tradewinds</p> <p>Services to ensure that all clients have a safe environment free of aggression</p> <p>from all sources including client on client aggression. It is also the policy</p> <p>of Tradewinds to ensure the health, welfare &amp; rights of the individuals we</p> <p>serve.</p> |                      |

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