

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G385	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/05/2014
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NAME OF PROVIDER OR SUPPLIER  TRADEWINDS SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 12046 FORREST DR ST JOHN, IN 46373
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W000000	<p>This visit was for the post certification revisit (PCR) to the investigation of complaint #IN00144005 conducted on 3/14/14.</p> <p>This visit was in conjunction with the investigation of complaint #IN00147437.</p> <p>Complaint #IN00144005: Not Corrected.</p> <p>Dates of Survey: May 2 and 5, 2014.</p> <p>Facility Number: 000899 Provider Number: 15G385 AIM Number: 100249270</p> <p>Surveyor: Christine Colon, QIDP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 5/12/14 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) 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 4 of 8 clients residing at the group home (clients A, E, F and H), 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 and documentation of incident reports.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports and investigations was conducted on 5/5/14 at 10:30 A.M. and indicated:</p> <p>-BDDS report dated 2/24/14 involving client H and a facility owned day program client indicated: "[Client H] was sitting at the table participating in an activity, when for no apparent reason [Day program peer] got up from his chair and hit [client H] in the middle of his back with his hand."</p>	W000149	TradeWinds has a policy on Abuse, Neglect, Exploitation, Mistreatment, and Protection of an Individuals' Rights and Injury of an unknown origin. The Policy States: "Violating an Individuals Rights, Abuse and or Neglect or any Mistreatment of any consumer who participates in a TradeWinds Services, Inc., program is strictly prohibited and will result in severe disciplinary action upto and include discharge from employment and may further result in criminal prosecution. All allegations of violating an Individuals rights or 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." (Please see attached Policies and Procedures on Abuse, Neglect, Exploitation, Mistreatment, and Protection of an Individuals' Rights and Injuries of an Unknown Origin) On 3/25/14, staffs were trained on: the Fall Risk Plans for the consumers in the Forest Group Home (Please see attached Training Record Sheet) On 4/10/14, a staff member was trained on: Fall Reporting for the consumers	05/14/2014

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	<p>-BDDS report dated 3/27/14 involving client H and a facility owned day program peer indicated: "On March 27, 2014 at approximately 9:00 A.M. [client H] was wheeling himself to the bathroom located within the ADAPT II room (day program room) where he attends day services. [Client H] is diagnosed with cerebral palsy and uses a wheelchair for transport, although he is very independent and uses a wheeled walker at home. He is able to transfer himself from his chair to the toilet and bed. After entering the bathroom and sitting down on the toilet another client [Day program peer] entered the bathroom and needing to use the toilet pushed [client H] on to the floor...."</p> <p>-BDDS report dated 4/6/14 involving client A indicated: "On April 7, 2014 when I arrived at the workshop at approximately 7:30 A.M. I was notified by the staff in ADAPT 1 that [client A] reported to them he had fallen at home on Sunday, April 6, 2014. He did have an abrasion to his left forearm that was about 2 1/2 inches long and about 1/4 inch wide approximately 3 inches past the elbow. When I questioned [client A] how this occurred he responded that he had gone into the bathroom and was pushed by a staff causing him to fall. There were no other witnesses to the</p>		<p>in the Forest Group Home (Please see attachedstaff development training report for the staff member) There was a medication adjustment for one of the aggressors (dayservice consumer) to prevent any further incidents and make sure that the otherconsumer's rights are protected. Also, another aggressor (day service consumer)started receiving behavioral services from Innovations in learning to helpmonitor the behaviors and to teach positive replacement behaviors to eliminatethe negative behaviors and to keep the consumers safe and others rightsprotected. A fall plan was updated/revised for Client H, who now has to havestaff present at all times to assist when using the shower, bathroom, walkingfrom place to place and for all ADLs. Staff will remain with Client H at alltimes when in the bathroom and assist Client H with leaving the bathroom toensure Client H's safety. The Consumers in the day program have been reassessedand moved into rooms more accommodating/appropriate to their skill levels.</p>		

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	<p>incident and neither the QIDP, Residential nurse or house manager had been notified until this morning." Further review of the record indicated the incident was unsubstantiated but did indicate staff involved in the incident failed to document an incident report of client A's fall at the group home.</p> <p>-BDDS report dated 4/9/14 indicated: "[Client F] was sitting in a chair in the ADAPT 2 area, [client E] was standing by the door. [Client F] stood up and [client E] grabbed his arm. [Client F] grabbed [client E]. Staff separated them immediately. Both were inspected and a scratch was noted on [client E]'s neck and scratch on [client F]'s left arm."</p> <p>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 conducted at the facility's administrative office on 5/2/14 at 3:00 P.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</p>			

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	<p>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."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/5/14 at 12:00 P.M.. The QIDP indicated staff at the day program are to stand outside the bathroom door at all times while clients are using the bathroom. The QIDP further indicated day program staff was not standing outside the door when this incident occurred to ensure client H was not physically aggressed upon while using the bathroom. The QIDP further indicated staff are to monitor all clients while at the day program to prevent client</p>			
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W000189	<p>to client aggression. The QIDP indicated the staff involved in the client A fall incident did not write an incident report and did not document client A's fall while in his bedroom. When asked if an incident report should have been documented, the QIDP stated "Yes."</p> <p>This deficiency was cited on 3/14/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p> <p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on record review and interview, the facility failed for 1 of 4 sampled clients (client A), to ensure staff were sufficiently trained to assure competence in documenting incidents.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports and investigations was conducted on 5/5/14 at 10:30 A.M. and</p>	W000189	TradeWinds has a policy on Abuse, Neglect, Exploitation, Mistreatment, and Protection of an Individuals' Rights and Injury of an unknown origin. The Policy Statement states: "Violating an Individuals Rights, Abuse and or Neglect or any Mistreatment of any consumer who participates in a TradeWinds Services, Inc., program is strictly prohibited and will result in severe disciplinary action upto and include discharge from employment and may further result in	05/14/2014

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	<p>indicated:</p> <p>-BDDS report dated 4/6/14 involving client A indicated: "On April 7, 2014 when I arrived at the workshop at approximately 7:30 A.M. I was notified by the staff in ADAPT 1 that [client A] reported to them he had fallen at home on Sunday, April 6, 2014. He did have an abrasion to his left forearm that was about 2 1/2 inches long and about 1/4 inch wide approximately 3 inches past the elbow. When I questioned [client A] how this occurred he responded that he had gone into the bathroom and was pushed by a staff causing him to fall. There were no other witnesses to the incident and neither the QIDP, Residential nurse or house manager had been notified until this morning." Further review of the record indicated the incident was unsubstantiated but did indicate staff involved in the incident failed to document an incident report of client A's fall at the group home.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/5/14 at 12:00 P.M.. The QIDP indicated this incident was not immediately reported by the staff who found client A in his room on the ground. The QIDP indicated the</p>		<p>criminalprosecution. All allegations of violating an Individuals rights or abuse andneglect of consumers served and certain other incidents defined in this policyare to be reported and investigated in prompt and procedurally correct manner."(Please see attached Policies and Procedures on Abuse, Neglect, Exploitation, Mistreatment, and Protection of an Individuals' Rights and Injuries of an Unknown Origin) On 3/25/14, staffs were trained on: the FallRisk Plans for the consumers in the Forest Group Home (Please see attached Training Record Sheet) On 4/10/14, a staff member was trained on: Fall Reporting for the consumers in the Forest Group Home (Please see attached staff development training report for the staff member) On 5/14/14, staffs were trained on: Group HomeProcedures, which consisted of: IR call procedure, nightly bed checks and housepetty cash usage (Please see attached Training Record and staff developmentreport forms)</p> <p>There was a medication adjustment for one of the aggressors (dayservice consumer) to prevent any further incidents and make sure that the otherconsumer's rights are protected. Also, another aggressor (day service consumer)started receiving behavioral services from Innovations in learning to helpmonitor the behaviors and to</p>		

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	<p>staff should have called her and submitted an internal incident report and documented on client A's daily logs. The QIDP indicated the staff did not document an incident report and did not call her. The QIDP indicated the staff did not document on client A's daily logs.</p> <p>This deficiency was cited on 3/14/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-3(a)</p>		<p>teach positive replacement behaviors to eliminatethe negative behaviors and to keep the consumers safe and others rightsprotected. A fall plan was updated/ revised for Client H, who now has to havestaff present at all times to assist when using the shower, bathroom, walkingfrom place to place and for all ADLs. Staff will remain with Client H at alltimes when in the bathroom and assist Client H with leaving the bathroom toensure Client H's safety. The Consumers in the day program have been reassessedand moved into rooms more accommodating/appropriate to their skill levels.</p>		