

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  07/11/2014
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NAME OF PROVIDER OR SUPPLIER  TRADEWINDS SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 220 E GREENWOOD CROWN POINT, IN 46307
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W000000	<p>This visit was for an annual recertification and state licensure survey.</p> <p>Dates of survey: July 1, 2, 3, 8 and 11, 2014.</p> <p>Facility number: 000705 Provider number: 15G171 AIM number: 100248690</p> <p>Surveyor: Christine Colon, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 7/28/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview, for 4 of 4 sampled clients and 3 additional clients (clients #1, #2, #3, #4, #5, #6 and #8), 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 preventing client to client aggression,</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 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	08/09/2014

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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	<p>and conducting thorough investigations.</p> <p>Findings include:</p> <p>1. An observation was conducted at the group home on 7/1/14 from 5:50 A.M. until 7:00 A.M.. At 5:41 A.M., client #2's nose was observed to be blue in color on the right side and he had a cut on the right side of his nose. Client #2's eyeglasses were crooked on his face. When asked by this surveyor what happened to his nose, client #2 did not respond. Direct Support Professional #1 (DSP) asked client #2 what happened to his nose and he looked around and did not respond. When DSP #1 was asked what happened to client #2, she stated "I don't know, I just came back to work yesterday. It looks like his glasses cut his nose."</p> <p>An interview with the Group Home Manager (GHM) was conducted at the group home on 7/2/14 at 5:32 P.M.. The GHM indicated staff found client #2 on his bedroom floor with the nose injury on Sunday. The GHM indicated an internal incident report was documented and client #2 went to the doctor's for an evaluation.</p> <p>A review of the investigation record dated 6/29/14 was submitted for review</p>		<p>insevere disciplinary action up to and include discharge from employment and mayfurther result 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)</p> <p>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 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, QIDP and Residential Nurse (if medical attention isneeded). The QIDP must be notified as soon as the incident is under control andthere is no further danger to either client(s) involved. The QIDP isresponsible for</p>	

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	<p>on 7/11/14 at 11:15 A.M.. Review of the record indicated:</p> <p>"5:53 A.M., Sunday 6/29/14: While enroute to the bedrooms to wake consumers for morning meds, staff heard a thump sounding like someone hitting the floor. Upon entering consumers [client #2] and [client #3]'s room; staff found [client #2] laying on the floor on his right side. Staff noticed that the consumer's nose was bleeding, staff got wet cold towel, cleaned blood around his nose, retrieved another cold towel used as compress to stop bleeding, leaned [client #2] down on his back, then raised him up so that he was sitting up. Consumer reached over to his bed and pulled himself up on the bed. Staff found his shoes up under him. Staff continued to use cold compress until bleeding stopped. Staff notified nurse at 5:40 A.M.; was told to put antibacterial and bandage on consumer's nose. Consumer was the brought into med office to get his meds. House Manager was notified at 5:45 A.M.. Upon shift ending staff checked consumer again, no bleeding was noticed. Signed and dated by DSP #13."</p> <p>"Investigation Form dated 6/29/14...Statement from DSP #14: On 6/29/14, [DSP #14] stated to the Qualified Intellectual Disabilities</p>		<p>making all necessary incident reports to the Bureau of Developmental Disabilities (BDDS) within the guidelines (within 24 hours of incident). TradeWinds Quality Assurance/Crisis Team meets monthly to review all internal incident reports in regards to all consumers. The Quality Assurance/Crisis Team also monitors trends for each incident.</p> <p>Investigation forms has been developed and implemented. One of the investigation forms is designed to have the individual, who is interviewed write down his/her summary of the incident that occurred and signoff. The revised/updated investigation form is designed to be extensive and very detailed. (Please see attached investigation forms)</p> <p>On 8/7/14, staffs were re-trained on the Abuse, Neglect, Exploitation, Mistreatment and Injury of Unknown Origin Policy. (Please see attached trainings)</p> <p>On 8/7/14, staffs were re-trained on client rights. (Please see attached trainings)</p> <p>On 8/8/14, the QIDPs were trained on how to conduct a thorough investigation. (Please see attached trainings)</p> <p>The group home manager is</p>	

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	<p>Professional (QIDP) that she really don't (sic) know what happened. [DSP #14] stated when she arrived to the room [client #2] was already on the floor and [DSP #13] then immediately asked me to contact the residential nurse. [DSP #14] stated she contacted the nurse at approximately 5:40 A.M. then she gave [DSP #13] the phone so that he could explain the incident and receive instructions from the nurse. [DSP #14] mentioned all she knows is that [DSP #13] stated to her that [client #2] tried to get out of the bed and fell."</p> <p>"On 7/1/14...[Client #2] was transported to urgent care for further observation. [Client #2] was diagnosed with Fractured Nasal Bones and Sinusitis."</p> <p>Further review of the investigation record failed to indicate client #2 and client #3 were interviewed in regard to the incident. The record also failed to indicate any clients at the group home were interviewed and failed to indicate the nurse was interviewed.</p> <p>2. A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports and investigations was conducted on 7/1/14 at 10:15 A.M. and indicated:</p>		<p>responsible for monitoring and ensuring that the staffs are following the rights of the consumers. In addition, the QDDP will observe during weekly unannounced visits that the staffs are following the rights of the consumers. It is the policy of TradeWinds Services to ensure that all clients have a safe environment free of aggression, exploitation, abuse, neglect and mistreatment. It is also the policy of TradeWinds to ensure the health, welfare and rights of the individuals we serve.</p> <p>To ensure and monitor the investigations that are conducted by the QIDP's, the Residential Coordinator will request a copy for review. When the investigation is completed, it will be reviewed by the Residential Coordinator and General Manager for review to ensure the investigations are thorough. A copy of all completed investigations will be kept by the residential coordinator and the original will be submitted to Human Resources for filing.</p>	

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	<p>Incident involving client #1:</p> <p>-BDDS report dated 4/4/14 involving client #1 and a facility owned day program client indicated: "On 4/4/14, the QIDP (Qualified Intellectual Disabilities Professional) was informed that [Day program client] hit [client #1] while he was sitting in the day program."</p> <p>Incidents involving client #2:</p> <p>-BDDS report dated 2/26/14 involving client #2 and a facility owned day program client indicated: "At 1:30 P.M. when returning from lunch [Day Program client] became aggressive and hit two other consumers (client #2)."</p> <p>-BDDS report dated 3/1/14 involving clients #2, #3, #5 and #8 indicated: "On 3/1/14, the QIDP was informed by the staff at the group home that [client #8] was in behavior. Staff stated that during breakfast the residents were all at the table eating. Then [client #3] began laughing and [client #8] punched [client #3] in the left eye and [client #8] told [client #3], 'Stop laughing at me.' Staff immediately intervened and separated both consumers. At approximately 10 A.M. this same morning [client #8] and [client #5] starting (sic) arguing with each other because [client #5] told [client</p>			

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	<p>#8] to get out of the refrigerator. [Client #8] attempted to hit [client #5] but staff was able to block [client #5] from being hit. As staff was walking [client #5], [client #8] reached around staff and hit [client #5] on the side of his face and [client #5] attempted to hit [client #8] back....Approximately 11 A.M. the same morning [client #8] threw a chair at a staff member and the chair missed the staff member [client #2] in the left leg (sic)."</p> <p>Incident involving client #3:</p> <p>-BDDS report dated 3/21/14 involving clients #3 and #6 indicated: "On Friday 3/21/14 at approximately 1:55 P.M., [client #3] was sitting at his work station when he began to yell, curse, and make obscene gestures. His trainer followed his Behavior Support Plan and redirected [client #3]. [Client #3] appeared to calm down. [Client #3] suddenly stood and slapped a peer (client #6) 2 times...."</p> <p>-BDDS report dated 4/30/14 involving clients #3 and #5 indicated: "At approximately 1:20 P.M., a general production trainer came to this writer with [client #3]. Staff stated that other peers in the same work area reported that a male peer, [client #5] had struck [client #3] on the head with his fist while they</p>			

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	<p>were in the hallway at the start of the afternoon break. The day services nurse examined [client #3] and reported that she found a small abrasion on [client #3]'s left ear lobe approximately .2 centimeters by .2 centimeters. There was also a small cut observed on the inside of his left upper lip."</p> <p>Incidents involving client #8:</p> <p>-BDDS report dated 10/14/13 involving clients #5 and #8 indicated: "On 10/14/13, the QIDP was informed that [client #8] had a behavior on the bus while in the parking lot of the center. Staff stated [client #8] became verbally and physically aggressive to staff because he didn't want [Staff name] to drive the van to the group home....While staff was redirecting [client #8], [client #5] reached over the seat and hit [client #8] in his arm."</p> <p>-BDDS report dated 2/19/14 involving client #8 and a facility owned day program client indicated: "While at the day service [Day Program client] walked behind [client #8] and hit the top of of his head."</p> <p>-BDDS report dated 4/7/14 involving clients #4 and #8 indicated: "On 4/7/14 at 6:30 A.M., [client #8] was in the</p>						

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	<p>dining room with [client #4]. Staff heard a disturbance. When the staff arrived in the dining room, they found [client #8] hitting [client #4] in the mouth and face area. Two of the staff redirected [client #8] into the living room. [Client #4] was directed to the Medical office due to injuries. By 6:38 A.M., [client #8] and [client #4] began to argue which resulted in [client #4] hitting [client #8] in the left eye."</p> <p>3. A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports and investigations was conducted on 7/1/14 at 10:15 A.M. and indicated:</p> <p>-BDDS report dated 11/21/13 involving client #2: "On 11/21/13, the Day Program Staff noticed a 2 cm (centimeter) length by 3 cm width size bruise on [client #2]'s right ear when staff was removing his hat off his head. The Day Program Staff reported that they did not know how the bruise appeared on [client #2]'s right ear. The Qualified Developmental Disabilities Professional (QDDP) investigated to see if any Group Home staff members or the House Manager was aware of how the bruise on [client #2]'s ear appeared. The result of the investigation is that neither Group Home Staff members nor the House</p>			

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	<p>Manager knew how the bruise appeared on the top of [client #2]'s right ear. [Client #2] was not able to communicate with staff how he received the injury." No written documentation was submitted for review to indicate all staff, client #2 and all clients at the group home were interviewed in regards to the documented injury of unknown injury. No investigation record was submitted for review in regards to this incident.</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 7/3/14 at 7:00 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 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</p>			

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	<p>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 at the facility's administrative office on 7/8/14 at 12:43 P.M.. The QIDP indicated there was no written documentation to indicate he interviewed all clients and all staff in regards to the mentioned incidents of injury of unknown origin. The QIDP indicated staff are to monitor all clients while at the group home and day program to prevent client to client aggression.</p> <p>9-3-2(a)</p>			

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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on observation, record review and interview for two incidents of injury of unknown origin, involving 1 of 4 sampled clients (client #2), the facility failed to provide written evidence thorough investigations were conducted.</p> <p>Findings include:</p> <p>1. An observation was conducted at the group home on 7/1/14 from 5:50 A.M. until 7:00 A.M.. At 5:41 A.M., client #2's nose was observed to be blue in color on the right side and had a cut on the right side of his nose. Client #2's eyeglasses were crooked on his face. When asked by this surveyor what happened to his nose, client #2 did not respond. Direct Support Professional #1 (DSP) asked client #1 what happened to his nose and he looked around and did not respond. When DSP #1 was asked what happened to client #2, she stated "I</p>	W000154	<p>All allegations of abuse, neglect, exploitation, mistreatment, injuries of unknown origin and etc... will be completely investigated; the investigation will start within 24 hours of the alleged incident. When there is an allegation of abuse, neglect, exploitation, mistreatment, injuries of unknown origin and etc... the staff member involved will be removed from the schedule immediately until such time as it is determined by a supervisory personnel that the individual is able to return to work, depending on the outcome of the thorough investigation. The QIDP must be notified as soon as the incident is under control and there is no further danger to either client involved. Along with notifying the QIDP, an internal incident report must be filled out and forwarded the incident report to the QIDP and Residential Nurse. The QIDP is responsible for making necessary incident reports to the Bureau</p>	08/09/2014

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	<p>don't know, I just came back to work yesterday. It looks like his glasses cut his nose."</p> <p>An interview with the Group Home Manager (GHM) was conducted at the group home on 7/2/14 at 5:32 P.M.. The GHM indicated staff found client #2 on his bedroom floor with the nose injury on Sunday. The GHM indicated an internal incident report was documented and client #2 went to the doctors for an evaluation.</p> <p>A review of the investigation record dated 6/29/14 was submitted for review on 7/11/14 at 11:15 A.M.. Review of the record indicated:</p> <p>"5:53 A.M., Sunday 6/29/14: While enroute to the bedrooms to wake consumers for morning meds, staff heard a thump sounding like someone hitting the floor. Upon entering consumers [client #2] and [client #3]'s room; staff found [client #2] laying on the floor on his right side. Staff noticed that the consumer's nose was bleeding, staff got wet cold towel, cleaned blood around his nose, retrieved another cold towel used as compress to stop bleeding, leaned [client #2] down on his back, then raised him up so that he was sitting up. Consumer reached over to his bed and pulled</p>		<p>ofDevelopmental Disabilities (BDDS) within the guidelines established by IndianaState Regulations (within 24 hours of the incident). ). TradeWinds QualityAssurance/Crisis Team meets monthly to review all internal incident reports in regards to all consumers. The Quality Assurance/Crisis Team also monitorstrends for each incident.</p> <p>Investigation forms has been developed and implemented. One of the investigation forms is designed to have the individual, who is interviewed write down his/her summary of the incident that occurred and signoff. The revised/updated investigation form is designed to be extensive and very detailed. (Please see attached investigation forms)</p> <p>On 8/8/14, the QIDPs were trained on how to conduct a thorough investigation. (Please see attached trainings)</p> <p>The group home manager is responsible for monitoring and ensuring that the staffs are following the rights of the consumers. In addition, the QDDP will observe during weekly unannounced visits that the staffs are following the rights of the consumers. It is the policy of TradeWinds Services to ensure that all clients have a safe environment free of aggression,</p>	

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	<p>himself up on the bed. Staff found his shoes up under him. Staff continued to use cold compress until bleeding stopped. Staff notified nurse at 5:40 A.M.; was told to put antibacterial and bandage on consumers nose. Consumer was the brought into med office to get his meds. House Manager was notified at 5:45 A.M.. Upon shift ending staff checked consumer again no bleeding was noticed. Signed and dated by DSP #13."</p> <p>"Investigation Form dated 6/29/14...Statement from DSP #14: On 6/29/14, [DSP #14] stated to the Qualified Intellectual Disabilities Professional (QIDP) that she really don't know what happened. [DSP #14] stated when she arrived to the room [client #2] was already on the floor and [DSP #13] then immediately asked me to contact the residential nurse. [DSP #14] stated she contacted the nurse at approximately 5:40 A.M. then she gave [DSP #13] the phone so that he could explain the incident and receive instructions from the nurse. [DSP #14] mentioned all she knows is the [DSP #13] stated to her that [client #2] tried to get out of the bed and fell."</p> <p>"On 7/1/14...[Client #2] was transported to urgent care for further observation. [Client #2] was diagnosed with Fractured Nasal Bones and Sinusitis."</p>		<p>exploitation, abuse, neglect and mistreatment. It is also the policy of TradeWinds to ensure the health, welfare and rights of the individuals we serve.</p> <p>To ensure and monitor the investigations that are conducted by the QIDP's, the Residential Coordinator will request a copy for review. When the investigation is completed, it will be reviewed by the Residential Coordinator and General Manager for review to ensure the investigations are thorough. A copy of all completed investigations will be kept by the residential coordinator and the original will be submitted to Human Resources for filing.</p>	

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	<p>Further review of the investigation record failed to indicate client #2 and client #3 were interviewed in regard to the incident. The record also failed to indicate any clients at the group home were interviewed and failed to indicate the nurse was interviewed.</p> <p>2. A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records was conducted on 7/1/14 at 10:15 A.M.. Review of the records indicated:</p> <p>-BDDS report dated 11/21/13 involving client #2: "On 11/21/13, the Day Program Staff noticed a 2 cm (centimeter) length by 3 cm width size bruise on [client #2]'s right ear when staff was removing his hat off his head. The Day Program Staff reported that they did not know how the bruise appeared on [client #2]'s right ear. The Qualified Developmental Disabilities Professional (QDDP) investigated to see if any Group Home staff members or the House Manager was aware of how the bruise on [client #2]'s ear appeared. The result of the investigation is that neither Group Home Staff members nor the House Manager knew how the bruise appeared on the top of [client #2]'s right ear.</p>			

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W000157	<p>[Client #2] was not able to communicate with staff how he received the injury." No written documentation was submitted for review to indicate all staff, client #2 and all clients at the group home were interviewed in regards to the documented injury of unknown injury. No investigation record was submitted for review in regards to this incident.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted at the facility's administrative office on 7/8/14 at 12:43 P.M.. The QIDP indicated there was no written documentation to indicate he interviewed all clients and all staff in regards to the mentioned incidents of injury of unknown origin.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS</p>				

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	<p>If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on observation, record review and interview, the facility failed for 1 of 4 sampled clients (client #2) to take effective/sufficient corrective action to prevent falls.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 7/1/14 from 5:50 A.M. until 7:00 A.M.. At 5:41 A.M., client #2's nose was observed to be blue in color and swollen on the right side and had a cut on the right side of his nose. Client #2's eyeglasses were crooked on his face. When asked by this surveyor what happened to his nose, client #2 did not respond. Direct Support Professional #1 (DSP) asked client #1 what happened to his nose and he just looked around and did not respond. When DSP #1 was asked what happened to client #2, she responded "I don't know, I just came back to work yesterday. It looks like his glasses cut his nose." During the entire observation period, client #2 walked with an unsteady gait. Client #2 walked swaying from left to right and leaned forward and backward as he walked. Direct Support Professionals (DSPs) #2 and #3 held client #2's arm and back of</p>	W000157	<p>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 up to 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)</p> <p>For all allegations of Abuse, Neglect, Exploitation, Mistreatment and Injuries of unknown origin, the investigation will start within 24 hours of the alleged incident. When there is an allegation of Abuse, Neglect, Exploitation, Mistreatment and Injuries of unknown origin the staff person(s) involved will be removed</p>	08/09/2014

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	<p>his shirt as he ambulated.</p> <p>An evening observation was conducted at the group home on 7/2/14 from 4:55 P.M. until 6:30 P.M.. During the entire observation period, client #2 walked with an unsteady gait. Client #2 walked swaying from left to right and leaned forward and backward as he walked. The GHM walked holding client #2 by his hands with his arms stretched out and she walked facing him as she led him around the home. DSP #5 assisted client #2 with ambulating by holding his arm and the back of his shirt.</p> <p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records was conducted on 7/1/14 at 10:15 A.M.. Review of the records indicated:</p> <p>-Internal report dated 6/29/14 involving client #2 indicated staff found client #2 on his bedroom floor and found the injury to his nose. Review of an investigation record dated 6/29/14 submitted on 7/8/14 at 12:00 P.M., indicated "Staff stated that on approximately Sunday 5:33 a.m. during his shift that he was walking to [client #2]'s bedroom to wake him for his a.m. medication when he heard a loud sound</p>		<p>immediately from the schedule pending outcome of the investigation. The staff person(s) involved is responsible for completing an internal incident report and notifying all necessary person(s), such as: House Manager, QIDP and Residential Nurse (if medical attention is needed). The QIDP must be notified as soon as the incident is under control and there is no further danger to either client(s) involved. The QIDP is responsible for making all necessary incident reports to the Bureau of Developmental Disabilities (BDDS) within the guidelines (within 24 hours of incident). TradeWinds Quality Assurance/Crisis Team meets monthly to review all internal incident reports in regards to all consumers. The Quality Assurance/Crisis Team also monitors trends for each incident.</p> <p>Investigation forms has been developed and implemented. One of the investigation forms is designed to have the individual, who is interviewed write down his/her summary of the incident that occurred and sign off. The revised/updated investigation form is designed to be extensive and very detailed. (Please see attached investigation forms)</p> <p>On 8/7/14, staffs were re-trained on the Abuse, Neglect, Exploitation, Mistreatment and Injury of</p>	

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	<p>coming from [client #2]'s bedroom. When he arrived in [client #2]'s room he found [client #2] lying on the floor. [Client #2] was laying on his right side facing toward the bed. Staff's assumption was that [client #2] fell out the bed and possibly hit his face on the brace of his shoes that were (sic) positioned on the floor next to the bed. Staff reported seeing blood on his nose. Staff went and got a towel and cold compress to stop the bleeding while he told another staff to call the nurse that was on call for that shift. On 7/1/14, [client #2] was transported to urgent care to follow up with a fall he had on 6/29/14...[Client #2] diagnosed with Fractured Nasal Bones (a break or crack in the bones of the nose) and Sinusitis (redness, soreness and swelling of the paranasal sinuses)."</p> <p>-BDDS report dated 6/18/14 indicated: "June 18, 2014 [client #2] was walking by a table where other consumers were working on an art project. [Client #2] grabbed one of the consumers (sic) paper and tore it up and as he was trying to get to the trash can, staff was behind [client #2] when he lost his balance. Staff was able to catch him, however he did fall to the floor in a sitting position. He did hit his right elbow on the floor. There was an abrasion to the right elbow, with a small nickel size bruise red, purple in</p>		<p>Unknown Origin Policy. (Please see attached trainings)</p> <p>On 8/7/14, staffs were re-trained on client rights.(Please see attached trainings)</p> <p>A toileting program and urination schedule has been developed and implemented for client #2. (Please see attached documents.</p> <p>On 8/7/14, all staffs were re-trained on the Fall Risk Plan for client #2. A fracture risk plan has been developed and implemented for client #2. A gait belt has been purchased by the Residential Nurse and has been implemented for client #2. (Please see attached documents)</p> <p>The group home manager is responsible for monitoring and ensuring that the staffs are following the rights of the consumers. In addition, the QIDP will observe during weekly unannounced visits that the staffs are following the rights of the consumers. It is the policy of TradeWinds Services to ensure that all clients have a safe environment free of aggression, exploitation, abuse, neglect and mistreatment. It is also the policy of TradeWinds to ensure the health, welfare and rights of the individuals we serve.</p> <p>To ensure and monitor the investigations that are conducted</p>	

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	<p>color."</p> <p>-BDDS report dated 4/5/14 indicated: "On April 5, 2014 at approximately 9:15 P.M. I received a call from staff at the group home reporting that [client #2] was found in his room, next to his bed, on the floor. Staff immediately got [client #2] up to his bed and did a complete evaluation. There were no visible (sic) injuries and [client #2] reported that he was not hurt."</p> <p>No documentation was available for review to indicate the facility took effective/sufficient corrective action to address the pattern of falls.</p> <p>A review of client #2's record was conducted on 7/2/14 at 1:30 P.M.. Client #2's record failed to indicate an assessment was completed to address his unsteady gait and documented falls.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted at the facility's administrative office on 7/8/14 at 12:43 P.M.. When asked if there was documentation to indicate the Inter Disciplinary Team (IDT) met to address each of the mentioned incidents, the QIDP indicated there was no documentation of IDTs to address the</p>		<p>by the QIDP's, the Residential Coordinator will request a copy for review. When the investigation is completed, it will be reviewed by the Residential Coordinator and General Manager for review to ensure the investigations are thorough. A copy of all completed investigations will be kept by the residential coordinator and the original will be submitted to Human Resources for filing.</p>	

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W000210	<p>falls. The QIDP indicated there was no documentation available for review to indicate the facility took sufficient/effective corrective action to address each of these incidents involving client #2's unsteady gait and falls with injury.</p> <p>9-3-2(a)</p> <p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on observation, record review and interview for 1 of 4 sampled clients (client #2), the facility failed to reassess client #2's mobility needs.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 7/1/14 from 5:50 A.M. until 7:00 A.M.. At 5:41 A.M., client #2's nose was observed to be blue in color and swollen on the right side and</p>	W000210	TradeWind Services has a weekly admissions team meetingheld for all new consumers prior to starting services at TradeWinds. During theadmissions team meeting, there is discussion of all items that will be requiredprior to his/her start date, if TradeWinds is able to meet the consumer(s) needsand to ensure that all documents and services are in place prior to the startdate of the new consumer(s). For the Greenwood consumers, the consumers areassessed on an annual basis or as needed in all areas, such	08/09/2014

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	<p>had a cut on the right side of his nose. Client #2's eyeglasses were crooked on his face. When asked by this surveyor what happened to his nose, client #2 did not respond. Direct Support Professional #1 (DSP) asked client #1 what happened to his nose and he looked around and did not respond. When DSP #1 was asked what happened to client #2, she stated "I don't know, I just came back to work yesterday. It looks like his glasses cut his nose." During the entire observation period, client #2 walked with an unsteady gait. Client #2 walked swaying from left to right and leaned forward and backward as he walked. Direct Support Professionals (DSPs) #2 and #3 held client #2's arm and back of his shirt as he ambulated.</p> <p>An evening observation was conducted at the group home on 7/2/14 from 4:55 P.M. until 6:30 P.M.. During the entire observation period, client #2 walked with an unsteady gait. Client #2 walked swaying from left to right and leaned forward and backward as he walked. The GHM walked holding client #2 by his hands with his arms stretched out and she walked facing him as she led him around the home. DSP #5 assisted client #2 with ambulating by holding his arm and the back of his shirt.</p>		<p>as: behavioral,medical, mobility and etc...</p> <p>The group home manager is responsible for monitoring and ensuring staff are following the program plan for each consumer. In addition,the QIDP will observe during weekly unannounced visits to ensure staff is following the program plan for each consumer.</p>				

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	<p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records was conducted on 7/1/14 at 10:15 A.M.. Review of the records indicated:</p> <p>-Internal report dated 6/29/14 involving client #2 indicated staff found client #2 on his bedroom floor and found the injury to his nose. Review of an investigation record dated 6/29/14 submitted on 7/8/14 at 12:00 P.M., indicated "Staff stated that on approximately Sunday 5:33 a.m. during his shift that he was walking to [client #2]'s bedroom to wake him for his a.m. medication when he heard a loud sound coming from [client #2]'s bedroom. When he arrived in [client #2]'s room he found [client #2] lying on the floor. [Client #2] was laying on his right side facing toward the bed. Staff's assumption was that [client #2] fell out the bed and possibly hit his face on the brace of his shoes that were (sic) positioned on the floor next to the bed. Staff reported seeing blood on his nose. Staff went and got a towel and cold compress to stop the bleeding while he told another staff to call the nurse that was on call for that shift. On 7/1/14, [client #2] was transported to urgent care to follow up with a fall he had on 6/29/14...[Client #2]</p>			

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	<p>diagnosed with Fractured Nasal Bones (a break or crack in the bones of the nose) and Sinusitis (redness, soreness and swelling of the paranasal sinuses)."</p> <p>-BDDS report dated 6/18/14 indicated: "June 18, 2014 [client #2] was walking by a table where other consumers were working on an art project. [Client #2] grabbed one of the consumers (sic) paper and tore it up and as he was trying to get to the trash can, staff was behind [client #2] when he lost his balance. Staff was able to catch him, however he did fall to the floor in a sitting position. He did hit his right elbow on the floor. There was an abrasion to the right elbow, with a small nickel size bruise red, purple in color."</p> <p>-BDDS report dated 4/5/14 indicated: "On April 5, 2014 at approximately 9:15 P.M. I received a call from staff at the group home reporting that [client #2] was found in his room, next to his bed, on the floor. Staff immediately got [client #2] up to his bed and did a complete evaluation. There were no visiable (sic) injuries and [client #2] reported that he was not hurt."</p> <p>A review of client #2's record was conducted on 7/2/14 at 1:30 P.M.. Client #2's record failed to indicate a</p>			

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W000289	<p>reassessment was completed to address his unsteady gait and documented falls. Client #2's current "Fall Risk" plan dated 1/14 did not indicate how he should be assisted with ambulation or how to prevent him from falling out of bed.</p> <p>An interview with the nurse was conducted on 7/2/14 at 2:15 P.M.. The nurse indicated client #2 had an unsteady gait when he walked and required assistance from staff. The nurse further indicated there was no current reassessment completed to address client #2's unsteady gait and documented falls. The nurse indicated client #2 has a fall risk plan but it does not address how he should be assisted with ambulation or addressed how to prevent him from falling out of bed.</p> <p>9-3-4(a)</p> <p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to</p>						

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	<p>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 additional client (client #8), the facility failed to ensure systematic interventions (physical holds) in the Behavior Support Plans (BSP) were specifically written/described.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports and investigations was conducted on 7/1/14 at 10:15 A.M. and indicated:</p> <p>-BDDS report dated 8/17/13 involving client #8 indicated: "On 8/19/13, the QDDP (Qualified Developmental Disabilities Professional) was informed [client #8] had a behavior on 8/17/13. Staff reported [client #8] became upset when he walked in the living room and discovered that the fan was on in the dining room. [Client #8] became verbally aggressive with staff. [Client #8] attempted to hit a staff member that was working in the home. Staff quickly intervened using an arm hold restraint to prevent being hit by [client #2]."</p> <p>-BDDS report dated 9/1/13 involving</p>	W000289	<p>The Greenwood Group Home has recently changed behavioral providers from Innovations in Learning to Clinical Psychology Center (CPC). The Greenwood consumers will be working with a new behaviorist from another agency. The new behaviorist has reviewed all previous Behavior Support Plans and is in the process of updating all BSP's that will give a thorough indication of what is least restrictive to the most restrictive measures during a behavior that involves a hold/restraint and using TradeWinds CPI techniques. A thorough description of the holds to be utilized by staff will be thoroughly listed in the BSP for each consumer to guide staff to ensure proper implementation. The QIDP 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 the BSP (client specific).</p> <p>All new hires, will receive CPI training and every 2 years all staff will receive a re-training on CPI or as needed to ensure staff can demonstrate competency. In</p>	08/09/2014

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	<p>client #8 indicated: "On 9/1/13, the QDDP received a call from staff stating that [client #8] was in behavior. [Client #8] walked in the medication room and attempted to go throught (sic) the medications. [Client #8] was picking up the telephone and dialing numbers of people he did not know. When staff redirected [client #8], he became verbally and physically aggressive. Staff had to restrain [client #8] using a two staff arm hold to direct him out of the medication room."</p> <p>-BDDS report dated 9/22/13 involving client #8 indicated: "On 9/23/13, the QDDP was informed [client #8] had a behavior on 9/22/13. Staff stated they assisted [client #8] with contacting his niece on the phone. After [client #8] was unable to get in contact with his family he became verbally and physically aggressive with staff. [Client #8] hit two staff members while displaying his behaviors. Staff had to restrain [client #8] using two staff arm hold."</p> <p>-BDDS report dated 2/22/14 involving client #8 indicated: "On 2/22/14 at approximately 7:15 A.M., [client #8] got upset because he was redirected from drinking water from the sink in the bathroom...[Client #8] came into the kitchen and displayed physical aggression</p>		<p>addition, all staff will receive behavioral training annually or as needed to ensure competency. All staff will be tested after the trainings and all staff must receive at least 80% or better on all test to ensure that staff can demonstrate competency. However, if staff receives a score below 80%, he/she must re-test until he/she has met the requirements of receiving an 80% or higher on all competency tests.</p>	

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	<p>towards staff. [Client #8] was again redirected by staff, per his BSP. However, [client #8] became upset again and displayed physical aggression towards staff again. During the incident, staff was hit and kicked several times by [client #8]. Although staff followed [client #8]'s BSP in accordance, [client #8] had to be restrained by staff. In the BSP it states: 'If physical aggression escalates to the point that he is a risk to himself or others, the least restrictive but most effective procedures of physical restraint should be used.'" Further review of the report failed to indicate what type of physical restraint was used by staff during this incident.</p> <p>A review of client #8's record was conducted on 7/3/14 at 1:15 P.M.. Review of client #8's BSP dated 10/29/13 indicated: "If physical aggression escalates to the point that he is a risk to himself or others, the least restrictive but most effective procedures of physical intervention should be used." Further review of the BSP did not indicate or describe what the least restrictive but most effective hold should be implemented when client #8 is a risk to himself or to others.</p> <p>An interview with the Qualified Intellectual Disabilities Professional</p>			

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W000488	<p>(QIDP) was conducted on 7/8/14 at 12:43 P.M.. The QIDP indicated client #8's BSP 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.</p> <p>9-3-5(a)</p> <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. Based on observation, record review and interview, the facility failed to assure 4 of 4 sampled clients (clients #1, #2, #3 and #4) were involved in meal preparation.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 7/1/14 from 5:50 A.M. until 7:00 A.M.. During the observation period, clients #1, #2, #3 and #4 sat in the living/dining room watching television. At 6:00 A.M., Direct Support</p>	W000488	<p>On 8/7/14, staffs at the Greenwood Group Home werere-trained on the Dining Areas and Services at the group home. (Please seeattached trainings) The group home manager is responsible for monitoring staffto ensure that the consumers are involved in the meal preparations. Inaddition, the QDDP's will also observe staff during weekly unannounced visitsto the group home to ensure the consumers are involved in the meal preparationsand serving the meals according to their level of</p>	08/09/2014

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	<p>Professional (DSP) #2 prompted client #6 to place the toasted english muffins on the table. At 6:05 A.M., clients #1, #2, #3 and #4 ate their morning meal independently. Clients #1, #2, #3 and #4 did not assist in meal preparation.</p> <p>An evening observation was conducted at the group home on 7/2/14 from 4:55 P.M. until 6:30 P.M.. During the observation period, clients #1, #2, #3 and #4 sat in the living/dining room watching television. At 5:00 P.M., the Group Home Manager (GHM) cooked the evening meal which consisted of taco meat, canned peaches, lettuce, tomato, refried beans and tortilla chips. At 5:30 P.M., clients #1, #2, #3 and #4 ate their evening meal independently. Clients #1, #2, #3 and #4 did not assist in meal preparation.</p> <p>A review of client #4's record was conducted on 7/2/14 at 4:00 P.M.. Review of client #4's Individual Support Plan (ISP) dated 5/5/14 indicated: "Will learn to prepare a breakfast food."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 7/8/14 at 12:43 P.M.. The QIDP indicated clients were capable of assisting in meal preparation and further indicated they should be assisting in meal preparation at all times.</p>		<p>functioning.</p> <p>A schedule has been developed and implemented to ensure the clients are involved in meal preparation. (Please see attached document)</p>				

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W009999	<p>9-3-8(a)</p> <p>State Findings</p> <p>460 IAC 9-3-1(b) The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p> <p>The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division: (19. Use of any physical or manual restraint.)</p> <p>This state rule is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to report the use of restraint for 1 additional client (client #8), to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of</p>	W009999	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 up to 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) For all allegations of Abuse, Neglect, Exploitation, Mistreatment and Injuries of unknown origin, the	08/09/2014

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	<p>Developmental Disabilities Services (BDDS) reports and investigations was conducted on 7/1/14 at 10:15 A.M. and indicated:</p> <p>-BDDS report dated 8/17/13 involving client #8 indicated: "On 8/19/13, the QDDP (Qualified Developmental Disabilities Professional) was informed [client #8] had a behavior on 8/17/13. Staff reported [client #8] became upset when he walked in the living room and discovered that the fan was on in the dining room. [Client #8] became verbally aggressive with staff. [Client #8] attempted to hit a staff member that was working in the home. Staff quickly intervened using an arm hold restraint to prevent being hit by [client #2]."</p> <p>A review of the Bureau of Developmental Disabilities Services (BDDS) reporting policy effective March 1, 2011 was conducted on 7/1/14 at 5:50 P.M.. The policy indicated: "It is the policy of the Bureau of Quality Improvement Services (BQIS) to utilize an incident reporting and management system as an integral tool in ensuring the health and welfare of the individuals receiving services administered by BDDS....Incidents to be reported to BDDS...Use of any physical or manual restraint regardless of: planning, human</p>		<p>investigation will start within 24 hours of the alleged incident. When there is an allegation of Abuse, Neglect, Exploitation, Mistreatment and Injuries of unknown origin the staff person(s) involved will be removed immediately from the schedule pending outcome of the investigation. The staff person(s) involved is responsible for completing an internal incident report and notifying all necessary person(s), such as: House Manager, QDDP and Residential Nurse (if medical attention is needed). The QDDP must be notified as soon as the incident is under control and there is no further danger to either client(s) involved. The QDDP is responsible for making all necessary incident reports to the Bureau of Developmental Disabilities (BDDS) within the guidelines (within 24 hours of incident). TradeWinds Quality Assurance/Crisis Team meets monthly to review all internal incident reports in regards to all consumers. The Quality Assurance/Crisis Team also monitors trends for each incident.</p> <p>The group home manager is responsible for monitoring and ensuring that the staffs are following the rights of the consumers. In addition, the QDDP will observe during weekly unannounced visits that the staffs are following the rights of the</p>	

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	<p>right committee approval, informed consent."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 7/8/14 at 12:43 P.M.. The QIDP indicated this incident was not immediately reported to the administrator or BDDS. The QIDP further indicated the incident should have been immediately reported to the administrator and within 24 hours to BDDS.</p> <p>9-3-1(b)</p>		<p>consumers. It is the policy ofTradeWinds Services to ensure that all clients have a safe environment free ofaggression, exploitation, abuse, neglect and mistreatment. It is also thepolicy of TradeWinds to ensure the health, welfare and rights of theindividuals we serve.</p> <p>To ensure and monitor the BDDS reports are completed bythe QIDP's in a timely manner, the Residential Coordinator will request a copyfor review.</p> <p>To ensure and monitor theinvestigations that are conducted by the QIDP's, the Residential Coordinatorwill request a copy for review. When the investigation is completed, it will bereviewed by the Residential Coordinator and General Manager for review toensure the investigations are thorough. A copy of all completed investigationswill be kept by the residential coordinator and a copy will be submitted toHuman Resources for filing.</p>		