

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 investigation of complaint #IN00147437.</p> <p>This visit was in conjunction with the post certification revisit (PCR) to the investigation of complaint #IN00144005 conducted on 3/14/14.</p> <p>COMPLAINT #IN00147437: Unsubstantiated, due to lack of sufficient evidence.</p> <p>Unrelated deficiencies cited.</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		
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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</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 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	05/14/2014

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	<p>[Day program peer] got up from his chair and hit [client H] in the middle of his back with his hand."</p> <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]</p>		<p>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)</p> <p>There was a medication adjustment for one of the aggressors (day service consumer) to prevent any further incidents and make sure that the other consumer's rights are protected. Also, another aggressor (day service consumer) started receiving behavioral services from Innovations in learning to help monitor the behaviors and to teach positive replacement behaviors to eliminate the negative behaviors and to keep the consumers safe and others rights protected. A fall plan was updated/revised for Client H, who now has to have staff present at all times to assist when using the shower, bathroom, walking from place to place and for all ADLs. Staff will remain with Client H at all times when in the bathroom and assist Client H with leaving the bathroom to ensure Client H's safety. The Consumers in the day program have been reassessed and moved into rooms more accommodating/appropriate to their skill levels.</p>				

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	<p>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>-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</p>						

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	<p>crime as defined...All allegations of abuse and neglect of consumers served and certain other incidents defined in this policy are to be reported and investigated in prompt and procedurally correct manner...Accidents and other injuries not defined as abuse or neglect must still be documented on the incident report form and reviewed according to policy and applicable standards...It is mandatory that all personnel follow this policy. This includes: reporting incidents immediately upon becoming aware of them, completing all forms as required by this policy...Physical abuse: willful infliction of injury...Verbal abuse: Oral, written and or gestured language that includes disparaging and derogatory remarks toward consumers...Exploitation. Financial, any deliberate misplacement, exploitation, or wrongful temporary or permanent use of an individual's belongings or money."</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</p>						

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W000189	<p>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 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>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. 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>	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	05/14/2014

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	<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 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</p>		<p>Neglect or anyMistreatment 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 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 anUnknown Origin) On 3/25/14, staffs were trained on: the FallRisk Plans for the consumers in the Forest Group Home (Please see attachedTraining Record Sheet) On 4/10/14, a staff member was trained on:Fall Reporting for the consumers in the Forest Group Home (Please see attachedstaff 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</p>				

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W000436	<p>(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 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>9-3-3(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review, and interview, the facility failed for 1 of 4 sampled clients (client B) to ensure client B's wheelchair fit properly.</p>	W000436	<p>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> <p>The QIDP followed up withAlicks (Wheelchair Company) in regards to Client B's wheelchair. Alicks was scheduledto send out are</p>	05/27/2014			

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	<p>Findings include:</p> <p>A morning observation was conducted at the group home on 5/5/14 from 6:00 A.M. until 7:10 A.M.. During the entire observation client B sat in a standard wheelchair leaned over to the right with his shoulders hunched inward. The wheelchair looked to be too small for client B. At 6:35 A.M., client B almost fell out of his wheelchair. This surveyor had to notify staff of client B's position. At 6:45 A.M., client B almost fell out of his wheelchair while leaning forward and to the right.</p> <p>An interview with Direct Support Professional (DSP) #2 was conducted on 5/5/14 at 7:00 A.M.. DSP #2 indicated client B used the standard wheelchair when not using his walker. DSP #2 stated client B's wheelchair seemed to be "too small."</p> <p>An interview with the Nurse was conducted on 5/5/14 at 11:30 A.M.. The nurse indicated client B may be sitting improperly in the wheelchair due to his size.</p> <p>9-3-7(a)</p>		<p>presentative to TradeWinds the week of 5/12/14 to look at Client B's wheelchair and pick up the script. However, Alicks did not arrive to TradeWinds to look at Client B's wheelchair and to pick up the script. The QIDP followed up with Alicks on: 5/16/14 and 5/19/14. The Residential Nurse faxed over are quest to Dr. San Juan for a new order for: Evaluation for custom wheelchair with appropriate width. The Residential Nurse received the script from Dr. San Juan. The QIDP faxed over a copy of the script on: May 16, 2014 to Alick's Wheelchair Company. Alick's is scheduled to come out to TradeWinds on: May 27, 2014 at TradeWinds to evaluation Client B's wheelchair. (Please see attached documents)</p> <p>On 5/27/14, Alicks came for Client B's wheelchair. It was recommended that Client B get a wheelchair with a 20 degree angle and one that is 20 inches instead of 18. The wheelchair was ordered on: 5/27/14, the process will take up 4 to 6 weeks to receive the new wheelchair for Client B.</p> <p>The Group Home Manager is responsible for ensuring that the consumer's adaptive equipment is in adequate care. There is an adaptive equipment form that has been developed to inform the house manager if there is a malfunction</p>		

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W009999	<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.</p> <p>This state rule is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed for 1 of 1 incident,</p>	W009999	<p>with the adaptive equipment for the consumers & it is also inform the house managers when the adaptive equipment requires immediate care. (Please see attached adaptive equipment form) In addition, the QIDP will observe the consumers adaptive equipment daily, while at the day program in addition to receiving the adaptive equipment form from staff at the end of each month to monitor the status of the consumer's adaptive equipment's.</p> <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 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</p>	05/14/2014

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	<p>involving 1 of 4 sampled clients (client A), to report a fall with injury 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 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 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</p>		<p>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 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 Home Procedures, which consisted of: IR, call procedure, nightly bed checks and house petty cash usage (Please see attached Training Record and staff development report forms) All staff was re-trained on the Policy and Procedure for Incident Reporting and Call Protocol. The training was designed to inform staff on what is Reportable, who the staff should contact/notify and to fill out an internal incident report form immediately after incident, following the call protocol and ensuring that the consumer(s) is safe. 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).</p>				

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	<p>failed to document an incident report of client A's fall at the group home.</p> <p>A review of the Bureau of Developmental Disabilities Services (BDDS) reporting policy effective March 1, 2011 was conducted on 5/5/14 at 11:00 A.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."</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 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>The day service coordinator is responsible for monitoring and ensuring that the staffs are following the rights of the consumers. In addition, the day service case managers will observe the day program and to ensure that staff are following the rights of the consumers. It is the policy of TradeWinds Services to ensure that all consumers have a safe environment free of aggression, exploitation, abuse, neglect and mistreatment. It is also the policy of TradeWinds Services to ensure the health, welfare and rights of the individuals we serve.</p>	