

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G177		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/22/2012	
NAME OF PROVIDER OR SUPPLIER  TRADEWINDS SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 8416 CLINE AVE CROWN POINT, IN 46307			
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W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: June 20, 21, and 22, 2012</p> <p>Facility number: 000711 Provider number: 15G177 AIM number: 100243200</p> <p>Surveyor: Tim Shebel, Medical Surveyor III</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed on June 28, 2012 by Dotty Walton, Medical Surveyor III.</p>	W0000					

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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W0137	<p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>Based on observation, interview, and record review, the facility failed to allow 1 of 4 sampled clients (client #2) to have personal possessions in her room.</p> <p>Findings include:</p> <p>Client #2 was observed at the group home on 6/20/12 from 4:02 P.M. until 7:00 P.M., and on 6/21/12 from 4:58 A.M. until 6:57 A.M. During the above observation periods, client #2's bedroom was noted to be void of personal items.</p> <p>Client #2 was interviewed on 6/20/12 at 6:33 P.M. Client #2 stated she would like to have make up items and varied personal items in her room but stated she could not "because of my behaviors."</p> <p>Direct care staff #4 was interviewed on 6/21/12 at 6:558 A.M. Direct care staff #4 stated client #2's personal property was removed from her room due to the client "throwing and breaking things."</p> <p>Client #2's records were reviewed on 6/21/12 at 8:50 A.M. A review of the</p>	W0137	<p>Client # 2's behavior support plan has been updated to include removal of her personal property. Client #2 has a history of destroying her personal property and as a result Client #2 has limite personal items. Client #2's personal items have been placed back in her room and several items have been mounted more securely so that they can not be used as weapons. Staff will continue to monitor Client #2 and when necessary remove items for her safety and the safety of others. When Client#2's behaviors subside her personal items will be returned to her room. The house manager is responsible fotr monitoring Client #2's behaviors and ensuring that her property is returned as soon as possible after her behaviors subside.</p>	07/01/2012			

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	<p>client's 3/14/12 Individual Program Plan failed to indicate and her 1/1/12 Behavior Management Plan indicated the client had behaviors of property destruction which were being addressed but did not indicate the client's personal property should be removed and retained.</p> <p>QDDP (Qualified Developmental Disabilities Professional) #1 was interviewed on 6/21/12 at 11:36 A.M. QDDP #1 stated client #2's personal property was removed due to destructive behaviors.</p> <p>9-3-2(a)</p>			

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W0264	<p>483.440(f)(3)(iii) PROGRAM MONITORING &amp; CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.</p> <p>Based on observation and interview, the facility's human rights committee failed to review the facility's practice of using an alarm on the entrance/exit door of the facility affecting 4 of 4 sampled clients (clients #1, #2, #3, and #4), living at the facility.</p> <p>Findings include:</p> <p>Clients #1, #2, #3, and #4 were observed at the group home during the 6/20/12 observation period from 4:02 P.M. until 7:00 P.M. and during the 6/21/12 observation period from 4:58 A.M. until 6:57 A.M. During the above observation periods, the main exit/entrance doors to the facility were noted to have an alarm attached. The alarm sounded anytime the clients would enter or exit the facility.</p> <p>Direct care staff #4 was interviewed on 6/21/12 at 6:58 A.M. Direct care staff #4 stated the alarms on the doors were for clients #1 and #2 who "had elopement</p>	W0264	The Behavior Specialist has presented the use of the alarm system to the Human Rights Committee for review, In addition, all clients of the group home have signed waivers acknowledging that they know about that alarm and agree with its use. The use of the alarm has also been incorporated into both Client 1 and 2's behavior supprot plan. The QMRP will be responsible for ensuring that all necessary documents are presented for HRC approval and that copies are available for review.	07/09/2012			

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	<p>risks."</p> <p>Program Coordinator #1 was interviewed on 6/21/12 at 11:36 A.M. Program Coordinator #1 indicated there were sounding alarms on all exit/entrance doors. Program Coordinator #1 further stated, "There is no use to review the HRC (Human Rights Committee) minutes because the use of the door alarms had not been reviewed by them (HRC) since the house opened about two and a half years ago."</p> <p>9-3-4(a)</p>			

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W0289	<p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart.</p> <p>Based on observation, record review, and interview, the facility failed to incorporate the use of door alarms into the Behavior Management Plans of 2 of 2 sampled clients (#1 and #2), with elopement behaviors for whom the alarms were used.</p> <p>Findings include:</p> <p>Clients #1 and #2 were observed at the group home during the 6/20/12 observation period from 4:02 P.M. until 7:00 P.M. and during the 6/21/12 observation period from 4:58 A.M. until 6:57 A.M. During the above observation periods, the main exit/entrance doors to the facility were noted to have an alarm attached. The alarm sounded anytime the clients would enter or exit the facility.</p> <p>Direct care staff #4 was interviewed on 6/21/12 at 6:58 A.M. Direct care staff #4 stated the alarms on the doors were for clients #1 and #2 who "had elopement risks."</p> <p>Client #1's record was reviewed on</p>	W0289	Please see W264	07/10/2012			

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	<p>6/21/12 at 7:37 A.M. A review of the client's 10/9/11 Behavior Management Plan indicated she had an addressed behavior of elopement from the facility. Further review failed to indicate the use of a door alarm was incorporated into her Behavior Management Plan.</p> <p>Client #2's record was reviewed on 6/21/12 at 8:10 A.M. A review of the client's 1/1/12 Behavior Management Plan indicated she had an addressed behavior of elopement from the facility. Further review failed to indicate the use of a door alarm was incorporated into her Behavior Management Plan.</p> <p>QDDP (Qualified Developmental Disabilities Professional) #1 was interviewed on 6/21/12 at 11:36 A.M. QDDP#1 indicated there were sounding alarms on all exit/entrance doors. QDDP #1 further indicated the use of door alarms was not addressed in client #1 and #2's respective Behavior Management Plans.</p> <p>9-3-5(a)</p>				

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W0295	<p>483.450(d)(1)(i) PHYSICAL RESTRAINTS</p> <p>The facility may employ physical restraint only as an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied.</p> <p>Based on record review and interview, the facility failed to define behavioral restraints/techniques to be utilized, from least to most restrictive, in the Behavior Support Plan of 2 of 2 sampled clients (clients #1 and #2), with a Behavior Management Plans which included the use of restraints.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 6/21/12 at 7:37 A.M. A review of client #1's 10/9/11 Behavior Management Plan indicated the client had addressed behaviors which included physical aggression. Listed interventions included the following: "If physical aggression escalates to the point that she (client #1) is a risk to herself or others, least restrictive but most effective procedures of physical restraint should be used. Therapeutic intervention (physical restraint use) trained by [facility] should be implemented." Further review of client #1's 10/9/11 Behavior Management Plan failed to indicate the specific behavioral restraints, from least to most</p>	W0295	<p>A use or restraint continuum has been added to the Behavior Support Plan of both Client #1 and #2. The continuum spells out what order restrictive measures are to be used in the event of a behavior problem, all of these restrictive measures are part of the CPI training that each employee receives before being placed on the schedule/ (1.) Verbal (2.) Blocking (3.) CPI Team control system hold in which two staff members restrain the client by the arms to protect the client and others from harm (4.) CPI Team Transport system hold in which two staff members escort the client to an area where they can calm down. (5.) CPI Intern Control hold, this is a one person arm hold used until the second staff member can get in position. Any use of restraint requires an incident report be completed by all staff involved and that the QMRP be notified so that a BDDS report can be completed. In all cases requiring restraint the Behavior Specialist receives a copy of the incident report for review and if necessary changes to the behavior support plan. The Group Home Manager is</p>	07/10/2012

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	<p>restrictive, to be utilized in the management of client #1's physically aggressive behaviors.</p> <p>Client #2's record was reviewed on 6/21/12 at 8:10 A.M. A review of client #2's 1/1/12 Behavior Management Plan indicated the client had addressed behaviors which included physical aggression and property destruction. Listed interventions included the following: "If physical aggression escalates to the point that she (client #1) is a risk to herself or others, least restrictive but most effective procedures of physical restraint should be used. Therapeutic intervention (physical restraint use) trained by [facility] should be implemented" and, "If [client #2] continues incidents of property destruction, [facility] approved methods of physical interventions should be implemented to prevent continued property destruction." Further review of client #2's 1/1/12 Behavior Management Plan failed to indicate the specific behavioral restraints, from least to most restrictive, to be utilized in the management of client #2's behaviors of physical aggression and property destruction.</p> <p>QDDP (Qualified Developmental Disabilities Professional) #1 was</p>		<p>responsible for monitoring staff during client behaviors incident and reviewing incident reports of the staff. The QMRP is responsible for working with the Behavior Specialist on developing useful plans to ensure client and staff safety.</p>	

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	interviewed on 6/21/12 at 11:36 A.M. QDDP #1 indicated specific restraint techniques and interventions were not identified within client #1 and #2's respective Behavior Management Plans.  9-3-5(a)				

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W0312	<p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.</p> <p>Based on record review and interview, the facility failed to assure psychotropic drug usage was addressed in the individual program plan of 1 of 2 sampled clients using psychotropic medications (client #2).</p> <p>Findings include:</p> <p>Client #2's medical records were reviewed on 6/21/12 at 7:22 A.M. A review of the client's 6/12 Medication Administration Record indicated client #2 was receiving Latuda 20 milligrams every morning (medication for Schizophrenia).</p> <p>Client #2's records were further reviewed on 6/21/12 at 8:10 A.M. A review of the client's 3/14/12 Individual Program Plan and her 1/1/12 Behavior Management Program failed to indicate client #2's use of Latuda, which included withdrawal criteria, was addressed.</p> <p>QDDP (Qualified Developmental Disabilities Professional) #1 was interviewed on 6/21/12 at 11:36 A.M.</p>	W0312	Client #2's Behavior Support Plan has been updated to include the use of Latuda. The drug was recently prescribed and had not been added to the behavior support plan. The Residential Nurse is responsible for forwarding copies of all medications used for behavior issues to the behavior specialist so that the drug can be incorporated in the behavior support plan. The Behavior Specialist along with the QMRP will be responsible for ensuring that all necessary Human Rights approval are received and that these documents are available for review.	07/10/2012			

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	<p>QDDP #1 indicated client #2 use of Latuda had not been incorporated into her Behavior Management Plan.</p> <p>9-3-5(a)</p>				