

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 06/26/2012
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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W0000	<p>This visit was for a full annual recertification and state licensure survey.</p> <p>Dates of Survey: June 19, 20, 21, 25, 26, 2012.</p> <p>Facility number: 000705 Provider number: 15G171 AIM number: 100248690</p> <p>Surveyors: Susan Reichert, Medical Surveyor III-Team Leader Amber Bloss, Medical Surveyor III</p> <p>The following federal deficiencies also reflect state findings in accordance with 469 IAC 9. Quality Review completed 7/2/12 by Ruth Shackelford, 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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W0132	<p>483.420(a)(8) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients who do work for the facility are compensated for their efforts at prevailing wages and commensurate with their abilities.</p> <p>Based upon observation and interview for 1 of 8 clients (client #7) residing in the group home, the facility failed to ensure client #7 was not required to do chores for other clients or work for the facility.</p> <p>Findings include:</p> <p>Observation was conducted at the group home on 6/20/12 between 5:45 AM and 7:00 AM. At 5:55 AM, staff #8 asked client #7 to tie client #8's shoes. Client #8 asked staff #8 why he wouldn't help him tie his shoes. Client #8 then blocked staff #8 from walking by him by pushing his walker in front of staff #8 and banging it. Client #7 tied client #8's shoes and Staff #8 thanked client #7 for tying client #8's shoes.</p> <p>At 6:41 AM on 6/20/12 during group home observation, staff #4 prompted client #8 to change his shirt. Client #7 was sitting near the fireplace watching T.V. when staff #4 came out with client #8's soiled shirt and asked client #7 to take the soiled shirt downstairs. Client #7</p>	W0132	The staff has been retrained on not having clients do chores that are staff responsibility. The Group Home Manager is responsible for monitoring staff to ensure that they are aware of client rights that they are not having clients do thing outside of their responsibility. The QMRP will also make at minimum monthly unannounced checks of the residence while the consumers are there to monitor staff colent interaction. A copy of the staff training logs are attached for review.	07/11/2012			

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	<p>took client #8's shirt downstairs.</p> <p>QDDP (Qualified Developmental Disabilities Professional) #1 and #2, the group home nurse, and the Director were interviewed on 6/20/12 at 3:20 PM. The Director indicated client #7 was not paid for assisting client #8. When asked whether staff should be prompting a client to assist another client, the Director indicated it would depend on the relationship of the two individuals. The QDDP stated "No, it isn't okay."</p> <p>9-3-2(a)</p>			

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W0148	<p>483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.</p> <p>Based on record review and interview for 4 of 4 Bureau of Developmental Disabilities Services (BDDS) reports reviewed, involving 1 of 4 sampled clients (client #2), the facility failed to immediately notify client #2's legal guardian of the incidents.</p> <p>Findings include:</p> <p>The facility's reportable incidents to BDDS (Bureau of Developmental Disabilities Services) from 6/19/11 to 6/19/12 were reviewed on 6/19/12 at 2:39 PM and included 4 BDDS reports for client #2.</p> <p>A BDDS report dated 5/28/12 indicated client #2 was found with a bruise under his eye and was taken to the doctor for evaluation.</p> <p>A BDDS report dated 10/26/11 indicated client #2 fell in the restroom.</p> <p>A BDDS report dated 8/18/11 indicated client #2 fell.</p> <p>A BDDS report dated 8/5/11 indicated client #2 fell in the restroom and</p>	W0148	The QMRP and Residential Nurse have been instructed to notify parents or guardians of any significate changes to any clients condition including but not limited to, serious injury, accidents, death, abuse or unauthorized absence of any client. It will be indicated on the incident report that the family or guardian was contacted. The residential coordinator will receive copies of all incident report and will moitor them to ensure that the necessary contact have been made.	07/11/2012			

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	<p>sustained a cut to his face and broke his glasses as a result of the fall. The reports were marked N/A (not applicable) for notification of guardian and did not include additional evidence client #2's guardian was notified.</p> <p>The Nurse was interviewed on 6/20/12 at 2:12 PM. She indicated she would need to check records for evidence of guardian notification of the BDDS reports involving client #2. The nurse stated on 6/21/12 at 10:22 AM via email that "While I remember speaking with (Client #2's legal guardian), I could not find written documentation."</p> <p>No further documentation was available for review to indicate client #2's legal guardian had been informed immediately of the incidents.</p> <p>9-3-2(a)</p>						

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W0192	<p>483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>Based on record review, interview and observation, the facility failed for 2 of 7 clients who received medications (clients #5 and #6), to ensure staff were trained to administer medications without error, failed to ensure 1 additional client (client #5) with diabetes received medical assessment and care for a wound, failed to report discrepancies between medication labels and the medication administration record, and failed to ensure medications were locked when not being administered for 4 of 4 sampled (clients #1, #2, #3, and #4), and for 4 additional clients (clients #5, #6, #7, and #8).</p> <p>Findings include:</p> <p>1. During medication administration on 6/19/12 beginning at 6:30 PM, staff #7 checked Client #8's blood pressure (BP) and indicated it was 113/60. Staff #7 administered Client #8's medication including Amlodipine 5 mg (milligrams).</p> <p>Client #8's 6/12 Medication Administration Record (MAR) was reviewed on 6/19/12 at 6:50 PM and indicated Amlodipine 5 mg TAB, one</p>	W0192	<p>The staff have been retrained on Medication Administration for all clients including client #8's blood pressure medication and following orders also on the administration of client #8's Amiodopine. Staff were also retrained on the requirement to immediately add new medications to the Medication Administration Record as soon as it is put into place. Clients#5's Novolog has been relabled to match the doctors orders and staff have been retrained on the order. In addition, the staff has been retrained on the need to contact the residential nurse anytime client #5 has anytype of wound because of the nature of his medical condition and the need to monitor for infection.All staff have been retrained on the corect procedure for taking client blood presure in accordance with the American Heart Association guidelines.The medication box for secure storage of Client # 5's novolog has been replaced and the staff have been instructed to let the nurse and the QMRP know immediately if there is any malfunction of the container so that it can be replaced. THE Group Home Manager is res[ponsible for monitor staff on a daily basis to ensure that all staff</p>	06/28/2012			

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	<p>tablet by mouth twice daily, unless BP (blood pressure) is less than 100/70. The MAR indicated client #8 had been given his blood pressure medication on 6/12/12 with a BP reading of 110/66, on 6/13/12 with a BP reading of 132/68, on 6/14/12 with a BP reading of 129/61, on 6/17/12 with a BP reading of 114/53, and on 6/18/12 with a BP reading of 102/55.</p> <p>Staff #7 was interviewed on 6/19/12 at 6:55 PM. When asked whether she should have withheld the Amlodipine 5 mg TAB due to Client #8's blood pressure being 113/60, she stated "they usually do that for 6 AM, not for 6 PM."</p> <p>Client #8's physician's orders were reviewed on 6/20/12 at 6:51 AM. Client #8's physician's orders dated 9/3/09 indicated "if systolic BP less than 110... hold BP Rx (prescription)."</p> <p>The Nurse was interviewed 6/20/12 at 6:51 AM. She indicated staff #7 should have withheld Amlodipine 5mg TAB when client #8's blood pressure reading was below 100/70 as indicated in the MAR.</p> <p>2. During medication administration on 6/19/12 beginning at 6:30 PM, staff #7 indicated she was withholding Client #8's medication of Lorazepam 0.5 mg TAB</p>		<p>are administering medications properly and to make sure that all medications are immediatly added to ehe MAR sheets when added to any clients medication regiment. The residential nurse and QMRP will make unanounced visits at minimum monthly to observe medication administration The Residential Nurse is responsible to monitor and make sure that all medications are labled properly.</p>	

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	<p>because it was not listed on the Medication Administration Record (MAR). Client #8's Lorazepam bubble pack had empty spaces where the medication had been pushed out of the pack and hand written next to the empty spaces the dates 6/16, 6/17, and 6/18. There were no initials next to the dates.</p> <p>Client #8's 6/12 Medication Administration Record (MAR) was reviewed on 6/19/12 at 6:50 PM. The MAR did not include the Lorazepam 0.5 mg TAB.</p> <p>Staff #7 was interviewed on 6/19/12 at 6:55 PM and when asked whether she was going to administer Client #8's Lorazepam 0.5 mg TAB, she stated "No, I'm not giving it because it's not written on the med sheet. The nurse will be notified first thing in the morning." When asked how staff would know who gave the medication, she stated, "You wouldn't know."</p> <p>The Nurse was interviewed on 6/20/12 at 6:51 AM. When asked whether staff #7 should have withheld Client #8's Lorazepam 0.5 mg TAB, she indicated staff have been trained in Med Core to write the medication on the MAR and that staff #7 should have immediately called the nurse for clarification. When asked if</p>			

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	<p>withholding this medication would be considered a medication error, the nurse stated, "Yes it would be a medication error."</p> <p>3. Observations were completed at the group home on 6/19/12 from 4:40 PM until 7:40 PM. During medication administration at 5:05 PM, staff #7 tested client #5's blood sugar which registered at 84. Client #5 was given an injection of Novolog 5 units (diabetes). The label on the Novolog indicated if blood sugar was less than 100, he was to receive 3 units. Client #5 had a scabbed wound around above the left side of his mouth 1/2 inch in diameter with reddened edges. Client #5 indicated he had been nicked while staff #9 shaved him.</p> <p>The 6/12 MAR (medication administration record) for client #5 was reviewed on 6/19/12 at 5:15 PM and indicated Novolog insulin-take 5 units immediately before each meal, breakfast, lunch and dinner. The MAR indicated client #5 had a diagnosis of diabetes. There was no evidence of treatment for client #5's wound listed in the MAR.</p> <p>Client #5's physician's orders dated 5/22/12 were reviewed on 6/20/12 at 7:30 AM and indicated he was to receive 5 units of Novolog before meals.</p>						

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	<p>The group home nurse was interviewed on 6/20/12 at 7:15 AM. She indicated the physician's orders, MAR and labels on client medications should match and client #5's Novolog should have a new label to reflect his current physician's orders. She indicated she was unaware of client #5's wound and when asked if she should have been notified to assess the wound due to client #5's diagnosis of diabetes, stated, "Absolutely. We have to be very cautious," and "Any cut is a concern."</p> <p>4. Observations were completed at the group home on 6/19/12 from 4:40 PM until 7:40 PM. During medication administration for client #8 beginning at 6:00 PM, staff #7 took client #8's blood pressure (BP) which measured 113/60. During the blood pressure check, staff #7 fastened a cuff around client #8's arm while he stood and his arm with the blood pressure cuff was dangling below his heart during the reading.</p> <p>The group home nurse was interviewed on 6/20/12 at 7:15 AM. She indicated client #8's blood pressure should be taken while sitting to ensure an accurate reading, and indicated staff were trained to take correct techniques to administer blood pressure readings.</p>			

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	<p>The American Heart Association website http://www.heart.org/HEARTORG/Conditions/High Blood Pressure/SymptomsDiagnosis... updated on 6/6/12 was reviewed on 6/26/12 at 8:45 PM and indicated blood pressure readings should be taken while sitting with both feet flat on the floor and arm at heart level.</p> <p>5. Observations were completed at the group home on 6/19/12 from 4:40 PM until 7:40 PM. During medication administration at 5:05 PM, client #5 was given an injection of Novolog 5 units (diabetes). The medication was then placed in a lock box and returned to a refrigerator.</p> <p>At 6:50 PM, staff #7 retrieved the medication box where the Novolog was stored in the refrigerator in the unlocked medication room. The box was unlocked, and staff #7 was unable to lock the box. Clients #1, #2, #3, #4, #5, #6, #7 and #8 had access to the medication room and refrigerator during the observation.</p> <p>Staff #7 was interviewed on 6/19/12 at 6:50 PM and indicated she was unable to lock the box to secure client #5's Novolog.</p>			

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	<p>The group home nurse was interviewed on 6/20/12 at 7:35 AM and when she retrieved the unlocked medication box, stated, "That's not good. They are overfilling." She indicated the box was to be locked.</p> <p>The group home nurse was interviewed on 6/20/12 at 7:15 AM. She indicated staff were trained to use Core A and B medication training to administer medications which included checking the medication labels with the MAR and physician's orders and to notify the nurse of discrepancies.</p> <p>The Living in the Community: Medication Administration Manual dated 2004 was reviewed on 6/26/12 at 3:30 PM and indicated on page 28 "Make sure that the information on the medicine sheet corresponds exactly to the label on the individual's medication. If it does not, ask the staff nurse for instructions...Do not leave medications unattended during preparation; if you must leave, place the medications in a locked area," on page 29, "Always remember to date and sign the medication sheet each time you administer a medication," and on page 144, "Individuals with diabetes must take extra precautions with all aspects of their health care. When caring for their skin, individuals with diabetes should avoid</p>			

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	<p>scratches, punctures and other injuries...All injuries should be treated promptly...If injuries do not start to heal within 24 hours, or if they become infected, contact the staff nurse...."</p> <p>9-3-3(a)</p>			

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W0249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based upon observation, interview and record review for 1 of 8 clients (client #8), the facility failed to ensure the Fall Risk Plan of his individual support plan (ISP) was implemented as written.</p> <p>Findings include:</p> <p>The facility's reportable incidents to Bureau of Developmental Services (BDDS) were reviewed on 6/19/12 at 2:39 PM. Client #8 had 4 reportable falls in the last year (7/7/11, 10/31/11, 2/03/12, 3/27/12). He sustained a cut to his head after tripping over his shoes and falling on 7/7/11, sustained a scrape on his forehead after tripping on his boots and falling on 10/31/11, and tripped over his feet and fell causing a small scrape on 2/3/12. There were no injuries indicated as a result of the fall reported on 3/27/12.</p> <p>Client #8 was observed at the group home on 6/20/12 between 5:45 AM and 7:00 AM. During the observation at 5:55 AM,</p>	W0249	All staff have been retrained on Client #8's fall risk plan and the need for staff monitoring client #8 to ensure that his footwear is properly fitted on his foot and that his shoes are tied properly. Staff have also been retrained on the the need for Client #8 to properly use his walker and to ensure that his pathway is clear of obstruction. The Group Home Manager is responsible for monitoring staff and ensuring that client #8's fall risk plan is being followed. In addition, the QMRP will make a minimum monthly unannounced visits to the group home to observe staff client interaction including the following of client risk plans.	06/28/2012			

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	<p>client #8 walked from the breakfast table to a living room chair using his walker with his shoes untied. Staff #2 approached client #8 and asked him if he could help him with his shoes, but Client #8 refused his assistance. Client #7 tied Client #8's shoes for him when staff #2 requested him to do so.</p> <p>At 6:31 AM, Client #8 walked to the couch while his shoes were only slipped on as his heels were sticking out the back. Staff #2 asked Client #8 to get up from the couch and return to the recliner so he could help him put his shoes on correctly. Client #8 attempted to walk back to the recliner but Client #5's walker and the coffee table were blocking his path. Client #5 pushed the coffee table out of the way, leaving Client #8 a one and 1/2 foot path to walk to the recliner. Client#8 sat in the recliner, then staff #2 assisted him with putting his shoes on correctly.</p> <p>Client #8's record was reviewed on 6/20/12 at 2:00 PM. Client #8's Fall Risk Plan indicated "staff will check (Client #8's) footwear to ensure they fit properly" and "staff will ensure that the hallways and classrooms are clear of obstacles."</p> <p>The Nurse was interviewed on 6/20/12 at 3:45 PM, When asked if client #8's fall risk plan was being implemented as</p>			

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	written during the observations on 6/20/12, she stated "No, that is not safe according to his risk plan. His path should be clear from obstacles," and indicated client #8's footwear should be fitted properly. 9-3-4(a)				

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W0331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on record review and interview, the facility's nursing services failed to ensure the instructions of the pharmacy label matched the physician's orders and medication administration record (MAR) for 1 of 16 medications administered involving 2 additional clients (clients #5 and #8), and failed for 1 additional client (client #8) to administer a blood pressure reading correctly.</p> <p>Findings include:</p> <p>1. Observations were completed at the group home on 6/19/12 from 4:40 PM until 7:40 PM. During medication administration at 5:05 PM, staff #7 tested client #5's blood sugar which registered at 84. Client #5 was given an injection of Novolog 5 units (diabetes). The label on the Novolog indicated if blood sugar was less than 100, he was to receive 3 units. Client #5 had a scabbed wound around above the left side of his mouth 1/2 inch in diameter with reddened edges. Client #5 indicated when asked that he had been nicked while staff #9 shaved him. During medication administration at 6:19 PM, client #5 received Furosemide 40 mg (milligrams) tab. The label on the</p>	W0331	<p>The Staff has been retrained on Client #5 medication protocol including when and how much of his medication are to be given. In addition, the staff have been told that they must notify the residential nurse anytime that client #5 has any type of wound due to his medical condition it is necessary to closely monitor any wound for infection including minor wounds. All of client #5's medication have been relabeled to ensure that they correctly correspond with the doctors orders and the Medication Administration Record. The residential nurse is responsible for ensuring that all labels on all medications are correct and correspond with doctors orders. The staff have also been retrained on notifying the residential nurse anytime that they might discover that any medication is improperly labeled so that it can be corrected. The staff has been retrained on the proper procedure for monitoring client #8's blood pressure, and following the doctors order for administering his medications including withholding Amlodipine. The Group Home Manager will monitor staff on a daily basis to ensure that they are following doctors orders and that the proper procedure is being</p>	06/28/2012			

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	<p>Furosemide included typewritten instructions he was to receive Furosemide every morning and also included a handwritten note he was to receive the medication at 5 PM.</p> <p>The 6/12 MAR (medication administration record) for client #5 was reviewed on 6/19/12 at 5:15 PM and indicated Novolog insulin-take 5 units immediately before each meal, breakfast, lunch and dinner. The MAR included type written instructions client #5 was to receive Furosemide 40 mg in the morning. A handwritten note to the side of the entry the MAR for Furosemide indicated he was to receive the medication at 6 PM. The MAR indicated client #5 had a diagnosis of diabetes. There was no evidence of treatment for client #5's wound listed in the MAR.</p> <p>Client #5's physician's orders dated 5/22/12 were reviewed on 6/20/12 at 7:30 AM and indicated he was to receive 5 units of Novolog before meals.</p> <p>2. Client #8's 6/12 Medication Administration Record (MAR) was reviewed on 6/19/12 at 6:50 PM and indicated Amlodipine 5 mg TAB, one tablet by mouth twice daily, unless BP (blood pressure) is less than 100/70. The MAR indicated client #8 had been given</p>		<p>followed for reading any clients blood pressure. The residential nurse will make at minimum monthly unannounced visits to monitor staff and ensure that staff are following doctors orders and that the proper procedure is being followed for monitoring blood pressure.</p>	

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	<p>his blood pressure medication on 6/12/12 with a BP reading of 110/66, on 6/13/12 with a BP reading of 132/68, on 6/14/12 with a BP reading of 129/61, on 6/17/12 with a BP reading of 114/53, on 6/18/12 with a BP reading of 102/55.</p> <p>Client #8's physician's orders were reviewed on 6/20/12 at 6:51 AM. Client #8's physician's orders dated 9/3/09 indicated "if systolic BP less than 110... hold BP Rx (prescription)."</p> <p>The Nurse was interviewed 6/20/12 at 6:51 AM. She indicated client #8 should have withheld Amlodipine 5 mg TAB when client #8's blood pressure reading was below 100/70 as indicated in the MAR.</p> <p>3. Observations were completed at the group home on 6/19/12 from 4:40 PM until 7:40 PM. During medication administration for client #8 beginning at 6:00 PM, staff #7 took client #8's blood pressure (BP) which measured 113/60. During the blood pressure reading, staff #7 fastened a cuff around client #8's arm while he stood and his arm with the blood pressure cuff was dangling below his heart during the reading.</p> <p>Client #8's 6/12 MAR was reviewed on 6/19/12 at 6:45 PM and did not include</p>				

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	<p>instructions or a protocol for taking a blood pressure reading.</p> <p>The group home nurse was interviewed on 6/20/12 at 7:15 AM. She indicated the physician's orders, MAR and labels on client medications should match and client #5's Novolog should have a new label to reflect his current physician's orders. She indicated she was unaware of client #5's wound and when asked if she should have been notified to assess the wound due to client #5's diagnosis of diabetes, stated, "Absolutely. We have to be very cautious," and "Any cut is a concern." She indicated client #8's blood pressure should be taken while sitting to ensure an accurate reading and indicated there was no written protocol or instructions for staff to take an accurate blood pressure reading.</p> <p>The American Heart Association website http://www.heart.org/HEARTORG/Conditions/High Blood Pressure/SymptomsDiagnosis... updated on 6/6/12 was reviewed on 6/26/12 at 8:45 PM and indicated blood pressure readings should be taken while sitting with both feet flat on the floor and arm while at heart level.</p> <p>9-3-6(a)</p>						

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W0368	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>Based on record review and interview, the facility failed for 1 of 7 clients who received medications (client #8), to administer medications per physician's orders.</p> <p>Findings include:</p> <p>Client #8's 6/12 Medication Administration Record (MAR) was reviewed on 6/19/12 at 6:50 PM and indicated Amlodipine 5mg TAB, one tablet by mouth twice daily, unless BP (blood pressure) is less than 100/70. The MAR indicated client #8 had been given his blood pressure medication on 6/12/12 with a BP reading of 110/66, on 6/13/12 with a BP reading of 132/68, on 6/14/12 with a BP reading of 129/61, on 6/17/12 with a BP reading of 114/53, on 6/18/12 with a BP reading of 102/55.</p> <p>Client #8's physician's orders were reviewed on 6/20/12 at 6:51 AM. Client #8's physician's orders dated 9/3/09 indicated "if systolic BP less than 110... hold BP Rx (prescription)."</p> <p>The Nurse was interviewed 6/20/12 at 6:51 AM. She indicated client #8 should</p>	W0368	The staff has been retrained on client #8's medications and the need to follow the doctors order for withholding the medication if his blood pressure is below the doctors order. The group home manager is responsible for monitor the staff on a daily basis to ensure that they are following the doctors orders. In addition the residential nurse and the QMRP will make unannounced month visits to the group home to observe staff and review records to ensure that all medications are being administered correctly and that all doctors order are being followed	06/28/2012			

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	<p>should have withheld Amlodipine 5mg TAB when client #8's blood pressure reading was below 100/70 as indicated in the MAR.</p> <p>9-3-6(a)</p>				

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W0369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based upon observation, record review and interview, the facility failed to ensure medications were administered without error for 2 of 7 medications administered affecting client #8.</p> <p>Findings included:</p> <p>1. During medication administration on 6/19/12 beginning at 6:30 PM, staff #7 checked Client #8's blood pressure and indicated it was 113/60. Staff #7 administered Client #8's medication including Amlodipine 5 mg (milligrams).</p> <p>Client #8's 6/12 Medication Administration Record (MAR) was reviewed on 6/19/12 at 6:50 PM and indicated Amlodipine 5mg TAB, one tablet by mouth twice daily, unless BP (blood pressure) is less than 100/70.</p> <p>Staff #7 was interviewed on 6/19/12 at 6:55 PM. When asked whether she should have withheld the Amlodipine 5 mg TAB due to Client #8's blood pressure being 113/60, she stated "they usually do that for 6 AM, not for 6 PM."</p>	W0369	<p>The staff have been retrained on the proper protocol for taking client blood pressure and the need to make sure that the medication administration follows the doctors orders. The staff have also been instructed that if there is ever a question on what the doctors order is that they are to contact the residential nurse for clarification. The staff has also been retrained on the need to immediately add any new medication to the medication administration record as soon as it is delivered to the group home and to chart the medication according to the physicians order when given and again to notify the residential nurse for clarification if necessary. The group home manager is responsible to daily monitoring of the staff to ensure that medications are being administered accorind to proper protocol and physicains orders. In addition, the residential nurse and the QMRP with make a minimum monthly visits to the group home to monitor and observe staff to ensure that all medication administration procedure are being followed.</p>	06/28/2012			

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	<p>Client #8's physician's orders were reviewed on 6/20/12 at 6:51 AM. Client #8's physician's orders dated 9/3/09 indicated "if systolic BP less than 110... hold BP Rx (prescription)."</p> <p>The Nurse was interviewed 6/20/12 at 6:51 AM. She indicated staff #7 should have withheld Amlodipine 5mg TAB on 6/19/12 for the 6 PM dose due to the blood pressure reading below 100/70 as the doctor's order indicated.</p> <p>2. During medication administration on 6/19/12 beginning at 6:30 PM, staff #7 indicated she was withholding Client #8's medication of Lorazepam 0.5 mg TAB because it was not listed on the Medication Administration Record (MAR).</p> <p>Client #8's 6/12 Medication Administration Record (MAR) was reviewed on 6/19/12 at 6:50 PM. The MAR did not include the Lorazepam 0.5mg TAB.</p> <p>Staff #7 was interviewed on 6/19/12 at 6:55 PM and when asked whether she was going to administer Client #8's Lorazepam 0.5mg TAB, she stated "No, I'm not giving it because it's not written on the med sheet. The nurse will be</p>			

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	<p>notified first thing in the morning."</p> <p>The Nurse was interviewed on 6/20/12 at 6:51 AM. When asked whether staff #7 should have withheld Client #8's Lorazepam 0.5 mg TAB, she indicated staff have been trained in Med Core to write the medication on the MAR and that staff #7 should have immediately called the nurse for clarification. When asked if withholding this medication would be considered a medication error, the nurse stated, "Yes it would be a medication error."</p> <p>Client #8's records were reviewed on 6/20/12 at 7:45 AM. A physician's order dated 5/18/12 indicated "Ativan (lorazepam) .5 mg twice daily."</p> <p>9-3-6(a)</p>			

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W0382	<p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration.</p> <p>Based on observation and interview for 4 of 4 sampled clients (clients #1, #2, #3 and #4), and 4 additional clients (clients #5, #6, #7 and #8), the facility failed to ensure medications were kept locked when not being administered.</p> <p>Findings include:</p> <p>Observations were completed at the group home on 6/19/12 from 4:40 PM until 7:40 PM. During medication administration at 5:05 PM, client #5 was given an injection of Novolog 5 units (diabetes). The medication was then placed in a lock box and returned to a refrigerator.</p> <p>At 6:50 PM, staff #7 retrieved the medication box where the Novolog was stored in the refrigerator in the unlocked medication room. The box was unlocked, and staff #7 was unable to lock the box. Clients #1, #2, #3, #4, #5, #6, #7 and #8 had access to the medication room and refrigerator during the observation period.</p> <p>Staff #7 was interviewed on 6/19/12 at 6:50 PM and indicated she was unable to lock the box to secure client #5's Novolog.</p>	W0382	The lock box has been replaced and the staff has been retrained on the need to immediately notify the residential nurse and the QMRP if there is ever a malfunction of the locking container for medications so that it can be replaced. The group home manager is responsible for daily monitoring of the group home including the proper storage and security of medications. In addition, the QMRP and residential nurse will check medication security at minimum monthly during unannounced visits of the group home.	06/28/2012			

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	<p>The group home nurse was interviewed on 6/20/12 at 7:35 AM and when she retrieved the unlocked medication box, stated, "That's not good. They are overfilling." She indicated the box was to be locked.</p> <p>9-3-6(a)</p>			
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W0455	<p>483.470(l)(1) INFECTION CONTROL</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>Based upon observation and interview, the facility failed to ensure proper hand washing and infection control procedures were implemented during the administration of medication for 1 of 4 sampled clients (client #2).</p> <p>Findings include:</p> <p>Observations were completed on 6/20/12 at the facility owned day services from 10:35 AM until 11:20 AM. At 10:55 AM, client #2 sat waiting to use the restroom in a chair next to the bathroom. Workshop client #9 sat in a chair next to client #2. When workshop client #9 went into the restroom, the back of her pants had wet stains about 2 feet by 2 feet in diameter, and the chair she was sitting in had a split down the length of the seat in the chair exposing the foam padding. Workshop client #9 left the bathroom without washing her hands. Client #2 used the restroom at 11:00 AM and left the restroom without washing his hands.</p> <p>Workshop staff #1 was interviewed on 6/20/12 at 11:10 AM and indicated chairs were cleaned daily. She indicated client</p>	W0455	<p>The staff at the group home and the day service program has been retrained on infection control including the need to immediately disinfect any service that become contaminated to prevent cross contamination from one client to another. At the day service program the program coordinator will be responsible for monitoring staff to ensure that protocol is followed when any containation occurs. At the group home the house manager is responsible on a daily basis to monitor staff and ensure that proper infection control protocols are ebing followed.</p>	07/11/2012	

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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		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>#9 had a wetting accident and when asked about cleaning the chair client #9 had been sitting on, she stated, "I'm going to do that," and "We try to get that done immediately." She indicated she would clean the foam exposed in the chair by wiping it down. When asked if there was soap available to use in the restroom used by clients #2 and #9, she indicated there was none available.</p> <p>The Director, group home nurse and QDDP (Qualified Developmental Disabilities Professional) #1 and #2 were interviewed on 6/20/12 at 3:45 PM. The Director indicated the chair would be replaced and soap would be made available for clients to use in the restroom.</p> <p>9-3-7(a)</p>				