

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 02/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRADEWINDS SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 12046 FORREST DR ST JOHN, IN 46373
---	--

(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
--------------------	--	---------------	---	----------------------

W 0000 Bldg. 00	<p>This visit was for the investigation of Complaint #IN00192347.</p> <p>COMPLAINT #IN00192347 - SUBSTANTIATED, Federal/State deficiencies related to the allegation are cited at W102, W104, W122, W149, W189, W210, and W259.</p> <p>Dates of Survey: February 11, 12, and 15, 2016.</p> <p>Facility number: 000899 Provider number: 15G385 AIM number: 100249270</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 2/22/16.</p>	W 0000		
W 0102	483.410			

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.

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 02/15/2016	
NAME OF PROVIDER OR SUPPLIER TRADEWINDS SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 12046 FORREST DR ST JOHN, IN 46373			
(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			
Bldg. 00	<p>GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on record review, observation, and interview, the Condition of Participation of Governing Body is not met as the facility's governing body failed to exercise general operating direction over the facility by failing to ensure the facility had an active program to maintain proper water temperatures to prevent burns for 1 of 4 sampled clients (client E).</p> <p>Findings include:</p> <ol style="list-style-type: none"> Please refer to W104 as the governing body failed to develop and implement a system of monitoring water temperatures to prevent 1 of 4 sampled clients (client E) from receiving burns from hot water at the facility. Please refer to W122 the Condition of Participation, Client Protections, as the governing body failed to protect 1 of 4 sampled clients (client E) from receiving burns from hot water at the facility. <p>This federal tag relates to complaint #IN00192347.</p> <p>9-3-1(a)</p>	W 0102	TradeWinds failed to exercise general operating direction over the facility had an active program to maintain proper water temperatures to prevent burns for 1 of 4 sampled clients. A water temperature testing protocol has been put into place. (Please see attached Water Temperature Testing Protocol) On 1/29/2016, staffs were trained on the Water Temperature Documentation and Water Scalding Training. (Please see attached training record) On 1/29/2016, staff has been trained on burns. (Please see attached training record) The DSP is responsible for checking the water temperatures for each consumer residing at the group home, prior to any contact with water. The DSP is responsible for testing the water prior to the client washing his/her hands, bathing, showering and completing any household tasks that may involve the use of tap water. The DSP is responsible for documenting the tested water temperatures on each individual's water temperature log. Each DSP is responsible for documenting the date, time, location of the water source (bathroom faucet, kitchen faucet, bathtub, shower or etc.) and water temperature. The	03/04/2016			

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 02/15/2016
NAME OF PROVIDER OR SUPPLIER TRADEWINDS SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 12046 FORREST DR ST JOHN, IN 46373		
(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	
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review, observation, and interview, the facility's governing body failed to exercise general operating direction over the facility by failing to develop and implement a system of monitoring water temperatures to prevent 1 of 4 sampled clients (client E) from receiving burns from hot water at the facility. Findings include:	W 0104	DSP testing and documenting the water testing is responsible for signing and making any comments in regard to concerns of the temperature taken. Water temperatures should not test higher than 110 degrees. If the temperature of water is higher than 110 degrees, the staff is to immediately contact the Group home manager, who will be given direction to the DSP on how to proceed. The Group Home Manager will be responsible for reviewing each log on a daily basis to ensure compliance. The QIDP will be responsible for reviewing the temperature log bi-weekly and report to the Residential Operations Coordinator the results and any concern of the water temperature log to ensure compliance. TradeWinds failed to exercise general operating direction over the facility had an active program to maintain proper water temperatures to prevent burns for 1 of 4 sampled clients. A water temperature testing protocol has been put into place. (Please see attached Water Temperature Testing Protocol) On 1/29/2016, staffs were trained on the Water Temperature Documentation and Water Scalding Training. (Please	03/04/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G385	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/15/2016
NAME OF PROVIDER OR SUPPLIER TRADEWINDS SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 12046 FORREST DR ST JOHN, IN 46373		
(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>The facility's records were reviewed on 2/11/16 at 10:33 A.M. A review of facility investigations and incident reports from 11/1/15 to 2/11/16 indicated the following:</p> <p>- "Date: 01/25/2016, Time: 5:00 A.M., On Sunday, January 24, 2016 staff (direct care staff) informed the residential nurse (nurse #2) that [client E] had a slight fever. There were no other symptoms including cough, nausea or congestion. [Client E] eat (sic) a full breakfast. Staff was instructed to give Tylenol for the fever and to push fluids. His (client E's) temperature began to come down. By 11:45 AM his (client E's) temperature was 99.4 (degrees fahrenheit) and his vitals were within normal limits. Staff was instructed to continue to take vitals including his temperature every 6 hours and give Motrin 200 mg (milligrams) every 6 hours as needed for temperature over 99.0 (degrees). This morning (1/25/16) the residential nurse was called that his (client E's) temperature was 99.4 (degrees) and that he (client E) had blisters to the head area and that he (client E) has lose (sic) control of his bladder, wetting the bed. He (client E) appeared somewhat disoriented and sluggish. There appeared to be three blisters to the head area. Client (client E)</p>		<p>see attached training record) On 1/29/2016, staff has been trained on burns. (Please see attached training record) The DSP is responsible for checking the water temperatures for each consumer residing at the group home, prior to any contact with water.</p> <p>The DSP is responsible for testing the water prior to the client washing his/her hands, bathing, showering and completing any household tasks that may involvethe use of tap water.</p> <p>The DSP is responsible for documenting the tested water temperatures on each individual's water temperature log.</p> <p>Each DSP is responsible for documenting the date, time, location of the water source(bathroom faucet, kitchen faucet, bathtub, shower or etc.) and water temperature.</p> <p>The DSP testing and documenting the water testing is responsible for signing andmaking any comments in regard to concerns of the temperature taken.</p> <p>Water temperatures should not test higher than 110 degrees. If the temperature of water is higher than 110 degrees, the staff is to immediately contact the Group home manager, who will be given direction to the DSP on how to proceed.</p> <p>The Group Home Manager will be responsible for reviewing each log on a daily basis to ensure</p>		

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 02/15/2016	
NAME OF PROVIDER OR SUPPLIER TRADEWINDS SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 12046 FORREST DR ST JOHN, IN 46373			
(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>was checked continuously throughout the night the (sic) these (blisters) were not discovered until 5:00 AM when staff tried to get him [client E] up for the day. Staff was advised to take [client E] immediately to [local hospital] in [local city] as that was the closest emergency facility and he (direct care staff #7) was met by the residential nurse shortly thereafter. Upon examination at the hospital he (client E) was found to have three, what appeared to be blisters, to the head. One was to the right side of the face approximately 1/2 inch wide and 1 1/2 inch long. The second was to the top of the head circumference. These did not appear until this morning when the client (client E) was awoken (sic). Blood work revealed an elevated shite (sic) (white) count. Urinalysis revealed a urinary tract infection. Chest x-ray was performed and the results are pending. Plan to Resolve: [Client E] has been admitted to [local hospital] in [local city] on a medical floor. IV (intravenous fluids) were started and he is receiving two antibiotics, Vancomycin and Rocephim by IV infusion. He (client E) will be assigned a hospitalist (physician) this AM who will further evaluate his (client E's) condition. He did eat a full breakfast at the hospital this morning and is resting comfortably."</p>		<p>compliance. The QIDP will be responsible for reviewing the temperature log bi-weekly and report to the Residential Operations Coordinator the results and any concern of the water temperature log to ensure compliance.</p>				

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 02/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRADEWINDS SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 12046 FORREST DR ST JOHN, IN 46373
---	--

(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>Client E's records were reviewed on 2/11/16 at 11:23 A.M. A review of the client's physician records from 1/28/16 indicated the following: "History of Presenting Illness - [Client E] is a 65 y.o. (year old) male patient who presents to [local hospital] with sepsis (infection) secondary to a complicated UTI (urinary tract infection) and multiple right forehead and occipital (head area) lesions consistent with thermal burns (second degree burns). Treat with Silvadene ointment (ointment for skin burns)."</p> <p>Building and Grounds Coordinator #1 was interviewed on 2/11/16 at 11:57 A.M. Building and Grounds Coordinator #1 stated, "The only thing we could figure out is that he (client E) was burned by hot water in the shower. We (the facility) just had a new water heater installed in the group home about six weeks ago. After it was installed, I turned the temperature of the hot water down so we could adjust it up if we needed to. I went over to the group home that day (1/25/16) to check the water heater and I noticed that someone had turned the heat up (to unknown temperature). Since then, I had an anti-scald device installed and the water temperatures are fine now."</p> <p>Client E was observed at the group home</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G385	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER TRADEWINDS SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 12046 FORREST DR ST JOHN, IN 46373
---	--

(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>on 2/12/16 from 5:00 A.M. until 7:00 A.M. Client E had small, scabbed over areas on his head.</p> <p>Direct care staff #1 was interviewed on 2/12/16 at 7:01 A.M. Direct care staff #1 stated, "Those scabbed areas on [client E's] head are from those burns. They (scabbed over areas) are healing and he (client E) sees the nurse every couple days. She (facility nurse) continues to check on him (client E)." Direct care staff #1 further stated, "We do water temperatures every day. We have to keep the temperature down below 110 degrees (fahrenheit)."</p> <p>On 2/12/16 at 9:43 A.M., the facility's 2/1/16 investigation results of client E's 1/25/16 injury of unknown origin were reviewed. The review of the investigation results concluded, in part, that the facility was "unable to to determine how the injuries of unknown origin occurred. The staff that was removed from the schedule (direct care staff #7) due to being the last person documented as showering [client E] and has been removed from this group home. All staff were trained on how to test and document water temperatures, and retrained on universal precautions specifically on burns and scalding." Further review of facility records failed to</p>			

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 02/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRADEWINDS SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 12046 FORREST DR ST JOHN, IN 46373
---	--

(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>indicate direct care staff took and recorded the water temperature at the group home prior to 1/27/16.</p> <p>Residential Operations Coordinator #1 was interviewed on 2/12/16 at 10:46 A.M. Residential Operations Coordinator #1 stated, "Our conclusion (of the investigation into the 1/25/16 incident involving client E) was that he was probably burned by hot water in the shower." When asked if the facility had a policy and procedure on testing and maintaining appropriate water temperatures for clients, Residential Operations Coordinator #1 stated, "I'm not sure if there was one prior to this incident (1/25/16 incident involving client E). It seems that all the group homes had tested water temps (temperature) differently prior to the incident (1/25/16 incident involving client E), but we (the facility) have one (water testing and documentation policy and procedure) now and it is being implemented and all staff (direct care staff) have been trained on it."</p> <p>The facility records were further reviewed on 2/12/16 at 11:07 A.M. The review indicated the facility had a policy and procedure dated 1/29/16 for maintaining water temperatures of 110 degrees fahrenheit of less. Review of</p>			

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 02/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRADEWINDS SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 12046 FORREST DR ST JOHN, IN 46373
---	--

(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
W 0122 Bldg. 00	<p>staff training records indicated direct care staff working at the group home were trained on 1/27/16 on maintaining water temperatures of 110 degrees fahrenheit or less. Review of water temperature log from 1/27/16 to 2/12/16 indicated direct care staff took water temperatures daily and all documented temperatures were 110 degrees fahrenheit or less.</p> <p>This federal tag relates to complaint #IN00192347.</p> <p>9-3-1(a)</p> <p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review, observation, and</p>	W 0122	TradeWinds neglected to protect	03/04/2016

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 02/15/2016
NAME OF PROVIDER OR SUPPLIER TRADEWINDS SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 12046 FORREST DR ST JOHN, IN 46373		
(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>interview, the Condition of Participation of Client Protections is not met as the facility neglected to protect 1 of 4 sampled clients (client E) from receiving burns from hot water at the facility.</p> <p>Findings include:</p> <p>Please refer to W149 as the facility neglected to implement their abuse/neglect policy to prevent 1 of 4 sampled clients (client E) from receiving burns from hot water at the facility.</p> <p>This federal tag relates to complaint #IN00192347.</p> <p>9-3-2(a)</p>		<p>1 of 4 sampled clients(client E) from receiving burns from hot water at the facility. A water temperature testing protocol has been put into place. (Please see attached Water Temperature Testing Protocol) On 1/29/2016, staffs were trained on theWater Temperature Documentation and Water Scalding Training. (Please see attached training record) On 1/29/2016, staff has been trained on burns. (Please see attached training record)</p> <p>The DSP is responsible for checking the water temperatures for each consumer residing at the group home, prior to any contact with water. The DSP is responsible for testing the water prior to the client washing his/her hands, bathing, showering and completing any household tasks that may involve the use of tap water. The DSP is responsible for documenting the tested water temperatures on each individual's water temperature log. Each DSP is responsible for documenting the date, time, location of the water source(bathroom faucet, kitchen faucet, bathtub, shower or etc.) and water temperature. The DSP testing and documenting the water testing is responsible for signing and making any comments in regard to concerns of the temperature taken. Water temperatures should not test higher than 110 degrees. If the temperature of water is higher</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G385	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER TRADEWINDS SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 12046 FORREST DR ST JOHN, IN 46373
---	--

(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
W 0149 Bldg. 00	<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, observation, and interview, the facility neglected to implement their abuse/neglect policy to prevent 1 of 4 sampled clients (client E) from receiving burns from hot water at the facility.</p> <p>Findings include:</p> <p>The facility's records were reviewed on 2/11/16 at 10:33 A.M. A review of facility investigations and incident reports from 11/1/15 to 2/11/16 indicated the following:</p> <p>- "Date: 01/25/2016, Time: 5:00 A.M., On Sunday, January 24, 2016 staff (direct</p>	W 0149	<p>than 110 degrees, the staff is to immediately contact the Group home manager, who will be given direction to theDSP on how to proceed. The Group Home Manager will be responsible for reviewing each log on a daily basis to ensure compliance. The QIDP will be responsible for reviewing the temperature log bi-weekly and report to the Residential Operations Coordinator the results and any concern of thewater temperature log to ensure compliance.</p> <p>TradeWinds neglected to implement the abuse/neglect policy to prevent 1 of 4 sampled clients (client E) from receiving burns from hot water at the facility. A water temperature testing protocol has been put into place. (Please see attached Water Temperature Testing Protocol) On 1/29/2016, staffs were trained on the Water Temperature Documentation and Water Scalding Training.(Please see attached training record) On 1/29/2016, staff has been trained on burns. (Please see attached training record) The DSP is responsible for checking the water temperatures for each consumer residing at the group home, prior to any contact with</p>	03/04/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G385	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER TRADEWINDS SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 12046 FORREST DR ST JOHN, IN 46373
---	--

(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
	care staff) informed the residential nurse (nurse #2) that [client E] had a slight fever. There were no other symptoms including cough, nausea or congestion. [Client E] eat (sic) a full breakfast. Staff was instructed to give Tylenol for the fever and to push fluids. His (client E's) temperature began to come down. By 11:45 AM his (client E's) temperature was 99.4 (degrees fahrenheit) and his vitals were within normal limits. Staff was instructed to continue to take vitals including his temperature every 6 hours and give Motrin 200 mg (milligrams) every 6 hours as needed for temperature over 99.0 (degrees). This morning (1/25/16) the residential nurse was called that his (client E's) temperature was 99.4 (degrees) and that he (client E) had blisters to the head area and that he (client E) has lose (sic) control of his bladder, wetting the bed. He (client E) appeared somewhat disoriented and sluggish. There appeared to be three blisters to the head area. Client (client E) was checked continuously throughout the night the (sic) these (blisters) were not discovered until 5:00 AM when staff tried to get him [client E] up for the day. Staff was advised to take [client E] immediately to [local hospital] in [local city] as that was the closest emergency facility and he (direct care staff #7) was met by the residential nurse shortly		water. The DSP is responsible for testing the water prior to the client washing his/her hands, bathing, showering and completing any household tasks that may involvethe use of tap water. The DSP is responsible for documenting the tested water temperatures on each individual's water temperature log. Each DSP is responsible for documenting the date, time, location of the water source(bathroom faucet, kitchen faucet, bathtub, shower or etc.) and water temperature. The DSP testing and documenting the water testing is responsible for signing and making any comments in regard to concerns of the temperature taken. Water temperatures should not test higher than 110 degrees. If the temperature of water is higher than 110 degrees, the staff is to immediately contact the Group home manager, who will be given direction to the DSP on how to proceed. The Group Home Manager will be responsible for reviewing each log on a daily basisto ensure compliance. The QIDP will be responsible for reviewing the temperature log bi-weekly and report to the Residential Operations Coordinator the results and any concern of the water temperature log to ensure compliance.	

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 02/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRADEWINDS SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 12046 FORREST DR ST JOHN, IN 46373
---	--

(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>thereafter. Upon examination at the hospital he (client E) was found to have three, what appeared to be blisters, to the head. One was to the right side of the face approximately 1/2 inch wide and 1 1/2 inch long. The second was to the top of the head circumference. These did not appear until this morning when the client (client E) was awoken (sic). Blood work revealed an elevated shite (sic) (white) count. Urinalysis revealed a urinary tract infection. Chest x-ray was performed and the results are pending. Plan to Resolve: [Client E] has been admitted to [local hospital] in [local city] on a medical floor. IV (intravenous fluids) were started and he is receiving two antibiotics, Vancomycin and Rocephim by IV infusion. He (client E) will be assigned a hospitalist (physician) this AM who will further evaluate his (client E's) condition. He did eat a full breakfast at the hospital this morning and is resting comfortably."</p> <p>Client E's records were reviewed on 2/11/16 at 11:23 A.M. A review of the client's physician records from 1/28/16 indicated the following: "History of Presenting Illness - [Client E] is a 65 y.o. (year old) male patient who presents to [local hospital] with sepsis (infection) secondary to a complicated UTI (urinary tract infection) and multiple right</p>			

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 02/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRADEWINDS SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 12046 FORREST DR ST JOHN, IN 46373
---	--

(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>forehead and occipital (head area) lesions consistent with thermal burns (second degree burns). Treat with Silvadene ointment (ointment for skin burns)."</p> <p>Building and Grounds Coordinator #1 was interviewed on 2/11/16 at 11:57 A.M. Building and Grounds Coordinator #1 stated, "The only thing we could figure out is that he (client E) was burned by hot water in the shower. We (the facility) just had a new water heater installed in the group home about six weeks ago. After it was installed, I turned the temperature of the hot water down so we could adjust it up if we needed to. I went over to the group home that day (1/25/16) to check the water heater and I noticed that someone had turned the heat up (to unknown temperature). Since then, I had an anti-scald device installed and the water temperatures are fine now."</p> <p>Client E was observed at the group home on 2/12/16 from 5:00 A.M. until 7:00 A.M. Client E had small, scabbed over areas on his head.</p> <p>Direct care staff #1 was interviewed on 2/12/16 at 7:01 A.M. Direct care staff #1 stated, "Those scabbed areas on [client E's] head are from those burns. They (scabbed over areas) are healing and he</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G385	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER TRADEWINDS SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 12046 FORREST DR ST JOHN, IN 46373
---	--

(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>(client E) sees the nurse every couple days. She (facility nurse continues to check on him (client E)." Direct care staff #1 further stated, "We do water temperatures every day. We have to keep the temperature down below 110 degrees (fahrenheit)."</p> <p>On 2/12/16 at 9:43 A.M., the facility's 2/1/16 investigation results of client E's 1/25/16 injury of unknown origin were reviewed. The review of the investigation results concluded, in part, that the facility was "unable to to determine how the injuries of unknown origin occurred. The staff that was removed from the schedule (direct care staff #7) due to being the last person documented as showering [client E] and has been removed from this group home. All staff were trained on how to test and document water temperatures, and retrained on universal precautions specifically on burns and scalding."</p> <p>The facility's training records were reviewed on 2/12/16 at 10:06 A.M. Review indicated all direct care staff working at the facility received training on "Water Temperature Testing and Documentation on 1/27/16. Further review of training records failed to indicate direct care staff who worked at the facility had received training on</p>			

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 02/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRADEWINDS SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 12046 FORREST DR ST JOHN, IN 46373
---	--

(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>"Water Temperature Testing and Documentation" prior to the 1/25/16 incident involving client E. Further review of facility records failed to indicate direct care staff took and recorded the water temperature at the group home prior to 1/27/16.</p> <p>Client E's record was reviewed on 2/12/16 at 10:22 A.M. Review of the client's record indicated an assessment for mixing hot and cold water was completed on 1/28/16. Further review failed to indicate client E's ability to mix hot and cold water was assessed prior to the 1/25/16 incident.</p> <p>Residential Operations Coordinator #1 was interviewed on 2/12/16 at 10:46 A.M. Residential Operations Coordinator #1 stated, "Our conclusion (of the investigation into the 1/25/16 incident involving client E) was that he was probably burned by hot water in the shower. We couldn't determine what staff might have been involved but we removed the last staff who showered [client E] from the group home." Residential Operations Coordinator further stated, "There is no record of staff (direct care staff working at the group home) ever being trained on testing water temperatures. I trained them on January 27th (2016) and [client E], there was no</p>			

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 02/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRADEWINDS SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 12046 FORREST DR ST JOHN, IN 46373
---	--

(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>record of him being assessed for his ability to mix hot and cold water prior to this incident (1/25/16 incident). I did his assessment on January 28th (2016)."</p> <p>When asked if the facility had a policy and procedure on testing and maintaining appropriate water temperatures for clients, Residential Operations Coordinator #1 stated, "I'm not sure if there was one prior to this incident (1/25/16 incident involving client E). It seems that all the group homes had tested water temps (temperature) differently prior to the incident (1/25/16 incident involving client E), but we (the facility) have one (water testing and documentation policy and procedure) now and it is being implemented and all staff (direct care staff) have been trained on it."</p> <p>The facility records were further reviewed on 2/12/16 at 11:07 A.M. The review indicated the facility had a policy and procedure dated 1/29/16 for maintaining water temperatures of 110 degrees fahrenheit or less. Review of staff training records indicated direct care staff working at the group home were trained on 1/27/16 on maintaining water temperatures of 110 degrees fahrenheit or less. Review of water temperature log from 1/27/16 to 2/12/16 indicated direct care staff took water temperatures daily</p>			

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 02/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRADEWINDS SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 12046 FORREST DR ST JOHN, IN 46373
---	--

(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
W 0189 Bldg. 00	<p>and all documented temperatures were 110 degrees fahrenheit or less.</p> <p>The facility's records were further reviewed on 2/12/16 at 1:57 P.M. A review of the facility's "Policy on Abuse & Neglect", dated 4/14 indicated, in part, the following: "b. Neglect includes failure to provide appropriate care, food, medical care or supervision."</p> <p>This federal tag relates to complaint #IN00192347.</p> <p>9-3-2(a)</p> <p>483.430(e)(1) STAFF TRAINING PROGRAM</p> <p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on record review and interview, the facility failed to train direct care staff</p>	W 0189	TradeWinds failed to train direct care staff working at the facility to monitor the water temperature at	03/04/2016

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 02/15/2016
NAME OF PROVIDER OR SUPPLIER TRADEWINDS SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 12046 FORREST DR ST JOHN, IN 46373		
(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>working at the facility to monitor the water temperature at the facility to prevent 1 of 4 sampled clients (client E) from receiving burns from hot water at the facility.</p> <p>Findings include:</p> <p>The facility's records were reviewed on 2/11/16 at 10:33 A.M. A review of facility investigations and incident reports from 11/1/15 to 2/11/16 indicated the following:</p> <p>- "Date: 01/25/2016, Time: 5:00 A.M., On Sunday, January 24, 2016 staff (direct care staff) informed the residential nurse (nurse #2) that [client E] had a slight fever. There were no other symptoms including cough, nausea or congestion. [Client E] eat (sic) a full breakfast. Staff was instructed to give Tylenol for the fever and to push fluids. His (client E's) temperature began to come down. By 11:45 AM his (client E's) temperature was 99.4 (degrees fahrenheit) and his vitals were within normal limits. Staff was instructed to continue to take vitals including his temperature every 6 hours and give Motrin 200 mg (milligrams) every 6 hours as needed for temperature over 99.0 (degrees). This morning (1/25/16) the residential nurse was called that his (client E's) temperature was 99.4</p>		<p>the facility to prevent 1 of 4 sampled clients (client E). A water temperature testing protocol has been put into place. (Please see attached Water Temperature Testing Protocol) On 1/29/2016, staffs were trained on the Water Temperature Documentation and Water Scalding Training.(Please see attached training record) On 1/29/2016, staff has been trained on burns. (Please see attached training record)</p>		

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 02/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRADEWINDS SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 12046 FORREST DR ST JOHN, IN 46373
---	--

(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
	(degrees) and that he (client E) had blisters to the head area and that he (client E) has lose (sic) control of his bladder, wetting the bed. He (client E) appeared somewhat disoriented and sluggish. There appeared to be three blisters to the head area. Client (client E) was checked continuously throughout the night the (sic) these (blisters) were not discovered until 5:00 AM when staff tried to wake him [client E] up for the day. Staff was advised to take [client E] immediately to [local hospital] in [local city] as that was the closest emergency facility and he (direct care staff #7) was met by the residential nurse shortly thereafter. Upon examination at the hospital he (client E) was found to have three, what appeared to be blisters, to the head. One was to the right side of the face approximately 1/2 inch wide and 1 1/2 inch long. The second was to the top of the head circumference. These did not appear until this morning when the client (client E) was awoken (sic). Blood work revealed an elevated shite (sic) (white) count. Urinalysis revealed a urinary tract infection. Chest x-ray was performed and the results are pending. Plan to Resolve: [Client E] has been admitted to [local hospital] in [local city] on a medical floor. IV (intravenous fluids) were started and he is receiving two antibiotics, Vancomycin and Rocephim			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G385	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/15/2016
NAME OF PROVIDER OR SUPPLIER TRADEWINDS SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 12046 FORREST DR ST JOHN, IN 46373		
(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>by IV infusion. He (client E) will be assigned a hospitalist (physician) this AM who will further evaluate his (client E's) condition. He did eat a full breakfast at the hospital this morning and is resting comfortably."</p> <p>Client E's records were reviewed on 2/11/16 at 11:23 A.M. A review of the client's physician records from 1/28/16 indicated the following: "History of Presenting Illness - [Client E] is a 65 y.o. (year old) male patient who presents to [local hospital] with sepsis (infection) secondary to a complicated UTI (urinary tract infection) and multiple right forehead and occipital (head area) lesions consistent with thermal burns."</p> <p>Building and Grounds Coordinator #1 was interviewed on 2/11/16 at 11:57 A.M. Building and Grounds Coordinator #1 stated, "The only thing we could figure out is that he (client E) was burned by hot water in the shower. We (the facility) just had a new water heater installed in the group home about six weeks ago. After it was installed, I turned the temperature of the hot water down so we could adjust it up if we needed to. I went over to the group home that day (1/25/16) to check the water heater and I noticed that someone had turned the heat up (to unknown</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G385	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER TRADEWINDS SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 12046 FORREST DR ST JOHN, IN 46373
---	--

(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>temperature). Since then, I had an anti-scald device installed and the water temperatures are fine now."</p> <p>On 2/12/16 at 9:43 A.M., the facility's 2/1/16 investigation results of client E's 1/25/16 injury of unknown origin were reviewed. The review of the investigation results concluded, in part, that the facility was "unable to to determine how the injuries of unknown origin occurred. The staff that was removed from the schedule (direct care staff #7) due to being the last person documented as showering [client E] and has been removed from this group home. All staff were trained on how to test and document water temperatures, and retrained on universal precautions specifically on burns and scalding."</p> <p>The facility's training records were reviewed on 2/12/16 at 10:06 A.M. Review indicated all direct care staff working at the facility received training on "Water Temperature Testing and Documentation on 1/27/16. Further review of training records failed to indicate direct care staff who worked at the facility had received training on "Water Temperature Testing and Documentation" prior to the 1/25/16 incident involving client E.</p>			

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 02/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRADEWINDS SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 12046 FORREST DR ST JOHN, IN 46373
---	--

(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>Residential Operations Coordinator #1 was interviewed on 2/12/16 at 10:46 A.M. Residential Operations Coordinator #1 stated, "Our conclusion (of the investigation into the 1/25/16 incident involving client E) was that he was probably burned by hot water in the shower. We couldn't determined what staff might have been involved but we removed the last staff who showered [client E] from the group home." Residential Operations Coordinator further stated, "There is no record of staff (direct care staff working at the group home) ever being trained on testing water temperatures. I trained them on January 27th (2016)."</p> <p>This federal tag relates to complaint #IN00192347.</p> <p>9-3-3(a)</p>			

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 02/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRADEWINDS SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 12046 FORREST DR ST JOHN, IN 46373
---	--

(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
W 0210 Bldg. 00	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN</p> <p>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 record review and interview the facility failed to assess the ability of 4 of 4 sampled clients at the facility (clients B, C, D, and E) to mix hot and cold water to prevent burns from hot water.</p> <p>Findings include:</p> <p>The facility's records were reviewed on 2/11/16 at 10:33 A.M. A review of facility investigations and incident reports from 11/1/15 to 2/11/16 indicated the following:</p> <p>- "Date: 01/25/2016, Time: 5:00 A.M., On Sunday, January 24, 2016 staff (direct care staff) informed the residential nurse (nurse #2) that [client E] had a slight fever. There were no other symptoms including cough, nausea or congestion. [Client E] eat (sic) a full breakfast. Staff was instructed to give Tylenol for the fever and to push fluids. His (client E's) temperature began to come down. By 11:45 AM his (client E's) temperature was 99.4 (degrees fahrenheit) and his vitals were within normal limits. Staff</p>	W 0210	TradeWinds failed to assess the ability of 4 of 4 sampled clients at the facility to mix hot and cold water to prevent burns from hot water. A water temperature testing protocol has been put into place. (Please see attached Water Temperature Testing Protocol) On 1/29/2016, staffs were trained on the Water Temperature Documentation and Water Scalding Training. (Please see attached training record) On 1/29/2016, staff has been trained on burns. (Please see attached training record)	03/04/2016

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 02/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRADEWINDS SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 12046 FORREST DR ST JOHN, IN 46373
---	--

(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>was instructed to continue to take vitals including his temperature every 6 hours and give Motrin 200 mg (milligrams) every 6 hours as needed for temperature over 99.0 (degrees). This morning (1/25/16) the residential nurse was called that his (client E's) temperature was 99.4 (degrees) and that he (client E) had blisters to the head area and that he (client E) has lose (sic) control of his bladder, wetting the bed. He (client E) appeared somewhat disoriented and sluggish. There appeared to be three blisters to the head area. Client (client E) was checked continuously throughout the night the (sic) these (blisters) were not discovered until 5:00 AM when staff tried to wake him [client E] up for the day. Staff was advised to take [client E] immediately to [local hospital] in [local city] as that was the closest emergency facility and he (direct care staff #7) was met by the residential nurse shortly thereafter. Upon examination at the hospital he (client E) was found to have three, what appeared to be blisters, to the head. One was to the right side of the face approximately 1/2 inch wide and 1 1/2 inch long. The second was to the top of the head circumference. These did not appear until this morning when the client (client E) was awoken (sic). Blood work revealed an elevated shite (sic) (white) count. Urinalysis revealed a urinary tract</p>			

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 02/15/2016	
NAME OF PROVIDER OR SUPPLIER TRADEWINDS SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 12046 FORREST DR ST JOHN, IN 46373			
(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>infection. Chest x-ray was performed and the results are pending. Plan to Resolve: [Client E] has been admitted to [local hospital] in [local city] on a medical floor. IV (intravenous fluids) were started and he is receiving two antibiotics, Vancomycin and Rocephim by IV infusion. He (client E) will be assigned a hospitalist (physician) this AM who will further evaluate his (client E's) condition. He did eat a full breakfast at the hospital this morning and is resting comfortably."</p> <p>Client E's records were reviewed on 2/11/16 at 11:23 A.M. A review of the client's physician records from 1/28/16 indicated the following: "History of Presenting Illness - [Client E] is a 65 y.o. (year old) male patient who presents to [local hospital] with sepsis (infection) secondary to a complicated UTI (urinary tract infection) and multiple right forehead and occipital (head area) lesions consistent with thermal burns."</p> <p>Building and Grounds Coordinator #1 was interviewed on 2/11/16 at 11:57 A.M. Building and Grounds Coordinator #1 stated, "The only thing we could figure out is that he (client E) was burned by hot water in the shower. We (the facility) just had a new water heater installed in the group home about six</p>						

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 02/15/2016
NAME OF PROVIDER OR SUPPLIER TRADEWINDS SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 12046 FORREST DR ST JOHN, IN 46373		
(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>weeks ago. After it was installed, I turned the temperature of the hot water down so we could adjust it up if we needed to. I went over to the group home that day (1/25/16) to check the water heater and I noticed that someone had turned the heat up. Since then, I had an anti-scald device installed and the water temperatures are fine now."</p> <p>On 2/12/16 at 9:43 A.M., the facility's 2/1/16 investigation results of client E's 1/25/16 injury of unknown origin were reviewed. The review of the investigation results concluded, in part, that the facility was "unable to to determine how the injuries of unknown origin occurred. The staff that was removed from the schedule (direct care staff #7) due to being the last person documented as showering [client E] and has been removed from this group home. All staff were trained on how to test and document water temperatures, and retrained on universal precautions specifically on burns and scalding."</p> <p>Client B's record was reviewed on 2/12/16 at 8:33 A.M. Review of the client's record indicated an assessment for mixing hot and cold water was completed on 1/28/16. Further review failed to indicate client B had been assessed for his ability to properly mix</p>				

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 02/15/2016	
NAME OF PROVIDER OR SUPPLIER TRADEWINDS SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 12046 FORREST DR ST JOHN, IN 46373			
(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>hot and cold water prior to the 1/25/16 incident involving client E.</p> <p>Client C's record was reviewed on 2/12/16 at 8:51 A.M. Review of the client's record indicated an assessment for mixing hot and cold water was completed on 1/28/16. Further review failed to indicate client C had been assessed for his ability to properly mix hot and cold water prior to the 1/25/16 incident involving client E.</p> <p>Client D's record was reviewed on 2/12/16 at 9:07 A.M. Review of the client's record indicated an assessment for mixing hot and cold water was completed on 1/28/16. Further review failed to indicate client D had been assessed for his ability to properly mix hot and cold water prior to the 1/25/16 incident involving client E.</p> <p>Client E's record was reviewed on 2/12/16 at 10:22 A.M. Review of the client's record indicated an assessment for mixing hot and cold water was completed on 1/28/16. Further review failed to indicate client E had been assessed for his ability to properly mix hot and cold water prior to the 1/25/16 incident.</p> <p>Residential Operations Coordinator #1</p>						

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 02/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRADEWINDS SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 12046 FORREST DR ST JOHN, IN 46373
---	--

(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>was interviewed on 2/12/16 at 10:46 A.M. Residential Operations Coordinator #1 stated, "Our conclusion (of the investigation into the 1/25/16 incident involving client E) was that he was probably burned by hot water in the shower. We couldn't determined what staff might have been involved but we removed the last staff who showered [client E] from the group home." Residential Operations Coordinator further stated, "There is no record of staff (direct care staff working at the group home) ever being trained on testing water temperatures. I trained them on January 27th (2016) and [client E], there was no record of those guys (clients B,C, D, and E) being assessed for their ability to mix hot and cold water prior to this incident (1/25/16 incident involving client E). I did those (clients B, C, D, and E's) assessments on January 28th (2016)."</p> <p>This federal tag relates to complaint #IN00192347.</p> <p>9-3-4(a)</p>			

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 02/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRADEWINDS SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 12046 FORREST DR ST JOHN, IN 46373
---	--

(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
W 0259 Bldg. 00	<p>483.440(f)(2) PROGRAM MONITORING & CHANGE</p> <p>At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed.</p> <p>Based on record review and interview, the facility failed to ensure the Comprehensive Functional Assessments for 4 of 4 sampled clients (clients B, C, D, and E) were completed and reviewed at least annually.</p> <p>Findings include:</p> <p>Client B's record was reviewed on 2/12/16 at 8:33 A.M. The review failed to indicate the client had a Comprehensive Functional Assessment had been completed within the last year.</p> <p>Client C's record was reviewed on 2/12/16 at 8:51 A.M. The review failed to indicate the client had a Comprehensive Functional Assessment completed within the past year.</p> <p>Client D's record was reviewed on 2/12/16 at 9:07 A.M. The review failed to indicate the client had a Comprehensive Functional Assessment</p>	W 0259	TradeWinds failed to ensure the Comprehensive Functional Assessments(clients B, C, D and E) were completed and reviewed at least annually. On 2/8/2016, the Comprehensive Functional Assessments (CFA's) for all of the Forest Group Home consumers were completed. (Please see attached Comprehensive Functional Assessments)	03/04/2016

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 02/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRADEWINDS SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 12046 FORREST DR ST JOHN, IN 46373
---	--

(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>completed within the past year.</p> <p>Client E's record was reviewed on 2/12/16 at 9:23 A.M. The review failed to indicate the client had a Comprehensive Functional Assessment completed within the past year.</p> <p>Residential Operations Coordinator #1 was interviewed on 2/12/16 at 9:37 A.M. Residential Operations Coordinator #1 stated, "Comprehensive Functional Assessments weren't completed for them (clients B, C, D, and E). It was overlooked by the former Q (Qualified Intellectual Disabilities Professional)."</p> <p>This federal tag relates to complaint #IN00192347.</p> <p>9-3-4(a)</p>			