

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G171	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/20/2021
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NAME OF PROVIDER OR SUPPLIER TRADEWINDS SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8286 E 101ST AVE CROWN POINT, IN 46307
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W 0000 Bldg. 00	<p>This visit was for a predetermined full recertification and state licensure survey. This visit included the COVID-19 focused infection control survey.</p> <p>Survey Dates: September 13, 14, and 20, 2021.</p> <p>Facility Number: 000705 Provider Number: 15G171 AIMS Number: 100248690</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 and #27547 on 9/30/21.</p>	W 0000		
W 0154 Bldg. 00	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 2 of 4 allegations of abuse, neglect, and exploitation reviewed, the facility failed to thoroughly investigate a fall for client #1 and peer to peer aggression for client #4.</p> <p>Findings include:</p> <p>The facility's Bureau of Developmental Disabilities Services (BDDS) reports and related investigations were reviewed on 9/13/21 at 2:34 pm.</p> <p>1. A BDDS report dated 8/21/21 indicated the following: "On 8/20/21 around 6:45 pm, [client #1] was leaving out of the group home walking with his</p>	W 0154	<p>The facility failed to have evidence that all alleged violations are thoroughly investigated as the facility failed to provide evidence of an investigation for a fall for client #1 and peer to peer aggression for client #4.</p> <p>To ensure systemic and ongoing compliance, on 9/21/2021 the facility expanded the areas of investigation to include all falls and peer to peer aggression in all areas of the facility, not group the group home setting.</p> <p>To ensure further systemic and ongoing compliance, the Director of Human Resources will oversee</p>	09/21/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>walker to get on the bus to go for ice cream. Staff stated he was anxious to get ice cream, and they were prompting him to slow down. [Client #1] stated, 'I lost my balance and fell on my right knee.' He had on shorts, so his right knee scraped on the side walk causing an abrasion 10 cm (centimeters) by 10 cm. Staff escorted [client #1] to [name of hospital] for evaluation and treatment by ER (emergency room) physician. X rays were taken of right knee and right hand, results negative. [Client #1] was discharged home with prescription cyclobenzaphrine (muscle relaxer) for pain." - The review did not include an investigation of client #1's fall.</p> <p>Group Home Director #1 was interviewed on 9/14/21 at 10:42 and and stated, "We did not do an investigation for [client #1's] fall. It was his first day in the home."</p> <p>2. A BDDS report dated 9/3/21 indicated the following: "At approximately 8:05 am on Friday, September 3, 2021, [day service peer #1] and [day service peer #2] were assisting with moving boxes. [Day service peer #1] became aggravated and started to make loud vocalizations and pushed a box aggressively enough to bump [day service peer #3] in the upper chest which [day service peer #3] ended up holding the box and walking away with it. [Day service peer #1's] actions caused [client #4] to hold his hand out in front of [day service peer #1] and tell him no. [Day service peer #1] proceeded to push [client #4] with both hands on [client #4's] upper chest. [Client #4] in turn did the same thing, causing [day service peer #1] to stumble backwards, landing on his backside. [Day service peer #1] immediately got up and started to go toward [client #4], a code 'C'</p>		all internal IRs to ensure all required incidents are investigated. General Managers will also check for compliance of investigations for incidents happening within their departments. Investigations will also regularly be reviewed for compliance.	

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W 0192 Bldg. 00	<p>(call for assistance) was called. Staff intervened and proceeded to escort [day service peer #1] to another room to deescalate. [Licensed Practical Nurse (LPN) #1] was called to assess [day service peers #1 and #2]. All participants had no complaints of pain, there was no redness, swelling, bruising, or bumps." - The review did not include an investigation of client #4's peer to peer aggression.</p> <p>Group Home Director #1 was interviewed on 9/14/21 at 10:42 am and stated, "The peer to peer was witnessed by several staff and was on video. [Day service peer #1] was suspended. The investigation was watching it on the camera."</p> <p>9-3-2(a) 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 observation, record review, and interview for 1 of 3 sample clients (#3), the facility failed to ensure staff working with client #3 were adequately trained to operate his manual hydraulic lift safely.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 9/13/21 from 4:00 pm until 6:30 pm. Client #3 was present in the home for the duration of the observation period.</p> <p>At 4:23 pm, Direct Support Professionals (DSPs) #2 and #3 prepared client #3 to be transferred from his wheelchair to his bed using</p>	W 0192	<p>The facility failed to ensure staff were adequately trained to operate the manual hydraulic lift safely for client #3.</p> <p>To ensure systemic and ongoing compliance, on October 13, 2021, DSPs #2 and #3 were retrained by the nursing staff on proper Hoyer Lift Procedures. The entire house staff was also retrained on Hoyer Lift Procedures during the house meeting on 10/13/2021.</p> <p>To ensure further systemic and ongoing compliance, the residential nurse will conduct weekly spontaneous visits to ensure staff compliance with</p>	10/13/2021

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	<p>a manual hydraulic lift. DSP #2 stated, "How do you want to do it?" DSP #3 stated, "I put the lift behind him." DSPs #2 and #3 maneuvered the lift into position behind client #3's wheelchair. Client #3 was facing away from the lift. DSP #2 locked the wheels on the wheelchair and the lift. DSPs #2 and #3 attached client #3's sling to the bars of the lift. DSP #3 unbuckled client #3's seat belt and chest strap. DSP #3 indicated client #3 was ready. DSP #2 began to raise the lift while DSP #3 held client #3's legs. DSP #3 stated, "Hold on. I forgot his foot straps." DSP #3 unbuckled client #3's Velcro foot straps. Client #3's right foot slipped between the foot rests of his wheelchair. DSP #2 continued raising the lift. Client #3's foot was caught between the foot rests of his wheelchair. DSP #2 continued raising the lift. Client #3's foot released from between the foot rests of his wheelchair. The chest strap attached to client #3's wheelchair was caught between client #3's right arm and the sling. DSP #3 stated, "Lower him." DSP #2 lowered client #3 back into his wheelchair. Client #3 bumped his head on the upright frame of the lift. DSP #3 stated, "Let's do it sideways. We can pivot instead of raising him over the back of the wheelchair." DSPs #2 and #3 detached client #3's sling from the lift and began moving the lift. The front right wheel of client #3's wheelchair was resting on top of the horizontal leg of the lift. DSP #2 pulled the lift backwards, and client #3's wheelchair tilted as the wheel came off of the lift leg. Client #3 bumped his head on the bar used to attached the sling to the lift. DSP #3 grabbed client #3 and fastened his seat belt.</p> <p>DSP #3 positioned client #3's wheelchair parallel to his bed. DSP #2 positioned the sling on the opposite side of client #3's wheelchair.</p>		<p>Hoyer lift procedures. The Residential Nurse will correct and retrain as needed if there are deficiencies in staff following procedures. The Residential Nurse will also train staff of all other group homes on the proper Hoyer lift procedures. All trainings were completed by 10/13/2021. The QIDP will also conduct weekly and monthly site checks to ensure Hoyer lift procedures are being safely implemented. The Residential Coordinator will also spot check safe Hoyer lift usage and procedure compliance during unannounced visits.</p>	

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	<p>DSP #2 locked client #3's wheelchair wheels and the wheels on the lift. DSPs #2 and #3 reattached client #3's sling to the lift. DSP #2 began to raise client #3 using the lift. A strap on client #3's sling was caught on the arm of the wheelchair. DSP #3 untangled the sling. DSP #2 raised client #3 to transfer him to his bed. The legs of the lift were behind and in front of client #3's wheelchair. DSP #2 stated, "Now what do we do?" DSP #3 stated, "I'll hold him, and you move the wheelchair." DSP #3 lifted client #3 and moved him and the sling away from the bed. DSP #2 attempted to push the wheelchair over the leg of the lift. DSP #2 picked up the wheelchair and moved it out of the way. DSP #3 carried client #3 to his bed and laid him down. DSP #2 lowered the lift, and DSPs #2 and #3 removed the sling from the lift.</p> <p>Client #3's record was reviewed on 9/14/21 at 10:47 pm.</p> <p>Client #3's wheelchair/Fall Risk Plan dated 10/8/20 indicated the following: "Fall prevention intervention. [Client #3] has been determined to be at risk for falls if a wheelchair safety protocol is not in place. Therefore, the following are interventions to be followed.</p> <ol style="list-style-type: none"> 1. Staff will listen for [client #3] to wake up during the night as this is the indication he needs to use the bathroom. Staff will go into his room and assist him in the transfer. 2. Staff will implement a toileting schedule for [client #3] in which he is taken to the bathroom every 2 hours while awake. 3. Staff must communicate to [client #3] when he will be transferring and verbally guide him during the transfer. Staff will also let [client #3] know what will happen or what to expect next. 4. Staff must always ensure that both brakes on 			

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	<p>the wheelchair are locked when [client #3] is being transferred.</p> <p>5. Turn the footrests (if applicable), so they are facing away from each other and out of the way of [client #3's] feet."</p> <p>A Residential Monthly Meeting note dated 2/10/21 indicated the following: "Agenda Topics: In this meeting we will discuss CPAP (continuous positive airway pressure), adaptive equipment, incident reporting, notifying the nurse. Hoyer Lift Procedure Use of Hoyer Lift Hoyer lifts should be used for non-weight bearing consumers or when a non-weight bearing consumer is not able to transfer from one space to another. The use of a Hoyer lift is determined by the consumer's physician and requires a written prescription. Manual Hoyer Lifts: Manual Hoyer lifts are sometimes called hydraulic lifts. Manual hydraulic lifts require hand-cranking, meaning the caregiver must generate counter-leverage by building lifting pressure manually. This always requires two staff. The brakes must be locked when moving the consumer. The staff must first position their consumer within the full-body sling, then hand-crank the Hoyer Lift to a raised position before maneuvering the patient. Each sling is individualized, such as a shower sling or the regular transfer sling. Staff will be trained on how to use the appropriate sling for the consumer."</p> <p>DSP #2 was interviewed on 9/13/21 at 6:17 pm and indicated he had worked in the group home for 4 years. DSP #2 stated, "I was trained to use the lift. I usually assist whoever is changing</p>			

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W 0440 Bldg. 00	<p>[client #3]. I usually position the lift on the side of the wheelchair. I prefer doing it on the side. It's easier that way."</p> <p>DSP #3 was interviewed on 9/13/21 at 6:23 pm and indicated he does not usually work in this group home. DSP #3 stated, "I was trained to use the lift. I put the wheelchair by the bed, and the lift by the wheelchair."</p> <p>Licensed Practical Nurse (LPN) #1 was interviewed on 9/14/21 at 12:45 pm and stated, "The lift should be positioned in front of the wheelchair. The client would be facing the lift. Staff should lock the wheels on the lift and the wheelchair. They should unbuckle the seat belt, chest strap, and foot straps. They attach the straps of the sling to the bar on the lift. One staff should stand behind the wheelchair, and the other person operates the lift. Once he's high enough, the first staff guides him to the transfer area. They should stabilize him, so he doesn't hit his head or bump into anything. Once he's in place, the second staff releases the hydraulics, so he can go down to the area where they want him. The sling is released from the bar, and they are ready to do whatever they need to do." LPN #1 indicated both DSPs #2 and #3 were trained to use the lift.</p> <p>9-3-3(a)</p> <p>483.470(i)(1) EVACUATION DRILLS at least quarterly for each shift of personnel. Based on record review and interview for 3 of 3 sample clients (#1, #2, and #3), plus 4 additional clients (#4, #5, #6 and #7), the facility failed to conduct evacuation drills for every shift at least quarterly.</p>	W 0440	The facility failed to ensure evacuation drills were completed at least quarterly for each shift of personnel for clients #1-7. To ensure systemic and ongoing	10/15/2021

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W 0455 Bldg. 00	<p>Findings include:</p> <p>The facility's evacuation drill records were reviewed on 9/13/21 at 5:20 pm and indicated the following: "First Quarter (January - March). 2/3/21, 5:30 am, 5-10 am. 2/11/21, 6:00 pm, 4 pm - 12 am. 2/20/21, 11:00 am, 8 am - 4 pm. 2/27/21, 3 am, 12 am - 8 am, sleep.</p> <p>Second Quarter (April - June) 4/11/21, 5 am, 12 am - 8 am, sleep. 5/22/21, 2 pm, 8 am - 4 pm.</p> <p>Third Quarter (July - September) 8/29/21, 10:30 am, 8 am - 4 pm."</p> <p>-The review indicated evacuation drills were not conducted for each shift in the second and third quarters for clients #1, #2, #3, #4, #5, #6 and #7.</p> <p>Residential Coordinator (RC) #1 was interviewed on 9/14/21 at 12:26 pm and stated, "Fire drills should be done once per quarter per shift."</p> <p>9-3-7(a)</p> <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 on observation, record review, and</p>	W 0455	<p>compliance, the house manager will be retrained on evacuation procedures, frequency and documentation during house manager meeting on 10/15/2021. All staff training on proper evacuation procedures and documentation occurred during house meeting on 10/13/2021. To ensure further systemic and ongoing compliance, all house managers will be retrained on evacuation procedures, frequency and documentation during monthly house manager meeting on 10/15/2021. Staff of all group homes were retrained on evacuation procedures, frequency and documentation by 10/13/2021. During weekly and monthly site checks, the QIDP will review evacuation logs to ensure compliance and will periodically alert the house of a drill to be performed immediately for additional compliance and practice. The Residential Coordinator will also spot check evacuation compliance during unannounced visits and may also initiate an evacuation drill to monitor compliance.</p> <p>The facility failed to ensure staff working in the home followed</p>	10/20/2021

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	<p>interview for 1 of 3 sample clients (#3), the facility failed to ensure staff working in the home followed universal precautions in regards to hand washing while assisting client #3 with her personal care.</p> <p>Findings include:</p> <p>An observation was conducted in the group home on 9/13/21 from 4:00 pm to 6:30 pm. Client #3 was present in the home for the duration of the observation period.</p> <p>On 9/13/21, Direct Support Professionals (DSPs) #2 and #3 assisted client #3 into his bed using a manual hydraulic lift. DSPs #2 and #3 placed client #3 on his back in his bed. DSPs #2 and #3 were wearing gloves. DSP #2 removed client #3's pants and wet brief. DSP #3 brought a damp wash cloth, and DSP #2 wiped then dried client #3's groin. DSP #2 patted client #3 on his head with his gloved hand. DSP #3 took client #3's brief and dirty clothing out of the bedroom. DSP #2 put a clean brief and shorts on client #2. DSP #2 did not change his gloves or wash his hands after removing client #3's brief. DSPs #2 and #3 transferred client #3 back into his wheelchair using the lift. DSP #2 and #3 went into the kitchen. DSP #3 removed his gloves and washed his hands. DSP #2 opened a kitchen cabinet and took out a cup. DSP #2 went to the garbage, removed his gloves, and washed his hands.</p> <p>DSP #2 was interviewed on 9/13/21 at 6:17 pm and stated, "I wash my hands immediately after we finish changing [client #3]. As soon as I can get to a sink."</p> <p>DSP #3 was interviewed on 9/13/21 at 6:23 pm</p>		<p>universal precautions in regards to hand washing while assisting client #3 with his personal care. To ensure systemic and ongoing compliance, staff #2 and #3, along with all group home staff for this location were retrained on universal precautions including hand washing on 10/13/2021. To ensure further systemic and ongoing compliance, during weekly and monthly site checks the QIDP will monitor for hand washing compliance. The Residential Coordinator will also spot check compliance of universal precautions during unannounced visits. Furthermore, the Residential Nurse will continue to conduct weekly spontaneous visits and audits to ensure staff compliance with policy and procedures. The Residential Nurse will correct and retrain as needed if there are deficiencies in staff following policies/ procedures. Audits are documented and submitted to the Residential Nurse Manager for review. The audits are reviewed by the Program Director monthly. The Residential Nurse will train the other residential homes on universal precautions by 10/20/2021.</p>	

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	<p>and stated, "I changed my gloves when I took the diaper to the trash."</p> <p>Licensed Practical Nurse (LPN) #1 was interviewed on 9/14/21 at 12:45 pm. LPN #1 stated, "When staff are putting on the new brief, they should change their gloves. They shouldn't have on the same gloves when they're getting the clean one out. They should change their gloves even if he's not wet."</p> <p>9-3-7(a)</p>			