

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G611	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/27/2011
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NAME OF PROVIDER OR SUPPLIER BLUE RIVER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 281 MCGRAIN ST CORYDON, IN47112
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W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>This visit was in conjunction with the post certification revisit (PCR) to complaint #IN00092145.</p> <p>Dates of Survey: October 17, 18, 19 and 27, 2011</p> <p>Facility Number: 001162 Provider Number: 15G611 AIM Number: 100385630</p> <p>Surveyor: Jo Anna Scott, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/17/11 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		
W0135	<p>The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have access to telephones with privacy for incoming and outgoing local and long distance calls except as contraindicated by factors identified within their individual program plans.</p> <p>Based on record review and interview for 1 of 4 sampled clients (client #4), the facility failed to ensure client #4 was</p>	W0135	Human Rights Committee (HRC) approval will be obtained to allow staff to monitor client 4's phone	11/29/2011

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>allowed to receive telephone calls in private.</p> <p>Findings include:</p> <p>The record review for client #4 was conducted 10/18/11 at 2:26 PM. Review of the client's rights restrictions indicated her telephone calls from her parents were to be limited and monitored. The restrictions indicated this was requested by Adult Protection Services (APS) on 8/12/11 in the most recent court order. The Human Rights Committee had approved the restriction of the phone calls from the parents on 2/14/11 but did not restrict the phone calls from friends.</p> <p>Interview with staff #5, on 10/18/11 at 5:00 PM indicated client #4 had her telephone calls monitored. Staff #5 indicated this was on all her calls and not just her parents' calls.</p> <p>Interview with staff #2, Home Manager on 10/19/11 at 1:30 PM stated client #4 had to have her phone calls monitored because some of the "calls caused behaviors." Staff #2, HM, indicated client #4 was only allowed to visit with her parents with supervision and the telephone calls with her parents were limited in time and were also monitored. Staff #2, indicated all phone calls were</p>		<p>calls.</p> <p>To protect other clients and prevent recurrence: The QMRP and group home manager assess the clients' files to ensure that all clients with human rights restrictions have HRC approval. Staff will understand the importance of obtaining approval for any action that infringes on the clients' rights. Staff will understand that no rights infringement can take place without prior HRC approval.</p> <p>Quality assurance: At the time of the case conference, the Interdisciplinary Team (IDT) will review the client's aversive plans and rights/restrictions to assess whether HRC approval is required. Responsible party: QMRP and group home manager.</p>		

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W0149	<p>monitored. Interview with staff #2, HM, indicated APS did not indicate all phone calls had to be monitored.</p> <p>Interview with staff #1, administrator, on 10/19/11 at 3:00 PM indicated client #4 had approval for the phone calls from the parents to be monitored according to APS serving as client #4's guardian and requesting the parents' calls being monitored. Staff #1 indicated all calls had not been approved to be monitored.</p> <p>9-3-2(a)</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview for 2 of 4 sampled clients (clients #3 and #4), the facility neglected to ensure the safety of client #4 after verbal threats had been made by client #3. The facility failed to implement their Neglect, Abuse, Mistreatment and Exploitation of Residents Policy dated 5/2011.</p> <p>Findings include:</p> <p>During the observation period on 10/17/11 from 4:15 PM to 7:00 PM, a monitor was noted in the group home</p>	W0149	<p>Batteries have been placed in the monitor for client 4 so that it is now portable and staff have been trained to carry it with them at all times.</p> <p>To protect other clients: The group home manager will train staff on the importance of complying with our Neglect, Abuse, Mistreatment, and Exploitation of Residents Policy. They will understand that the policy is for our clients' well-being and the potential repercussions of not complying with the policy.</p> <p>To prevent recurrence: The behavior specialist will receive all</p>	11/29/2011	

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	<p>office. At 5:15 PM a conversation could be heard on the monitor that was in the office area. The conversation was being held in the apartment of clients #3 and #4. Staff #4 was in the apartment discussing the meal with client #4. The monitor heard if you were in the office area, but staff could not hear the monitor when they were in one of the other apartments.</p> <p>The Bureau of Developmental Disabilities Services (BDDS) incident reports were reviewed on 10/17/11 at 1:45 PM. The BDDS report dated 8/25/11 for client #3 indicated "Upon arrival at the workshop, [client #3] shoved past (staff's name) when entering the building. (Group home) staff, (staff #3) then came to the door and (workshop staff #8) asked what was wrong with [client #3]. (Group home staff), staff #3, stated she had a problem with her roommate the night before. (Workshop staff #9) then overheard [client #3] say she was going to stab [client #4] to death. (Workshop staff #9) asked [client #3] not to say this and she kept repeating she was going to stab [client #4]. (Group home staff), staff #3, then told (workshop staff #9) and (workshop staff #10) that there had been an incident the night before involving [client #3 and her roommate [client #4] and we would want to keep a close eye on them. (Workshop staff #9) had</p>		<p>incident reports. He will review them quarterly to asses whether the clients' Behavioral Support Plan (BSP) must be changed or HRC approval should be obtained to prevent the incident from escalating.</p> <p>Quality assurance: The QMRP will ensure that any changes to the BSP are made, that the BSP is filed for staff accessibility, and that the staff is made aware of changes.</p> <p>Responsible party: QMRP and behavior specialist.</p>		

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	<p>(workshop staff #10) to clock in early in order for (workshop staff #9) to supervise the consumers involved in the situation. A male consumer, (initials of consumer) reported to (workshop staff #9) that he was at the candy machine and heard [client #3] say she was going to kill [client #4] tonight after work. (Workshop staff #9) asked [client #3] if she could look inside her lunchbox and [client #3] said 'no'. (Workshop staff #9) then had [client #4 come to an office with her until [client #3] left the shop to go to her off site job."</p> <p>The record review for client #3 was conducted on 10/18/11 at 12:31 PM. The Social Service record dated 8/25/11 indicated client #3 went home with her mother the night of 8/25/11 and would stay through 9/5/11 to ensure the safety of client #4. The Social Service record dated 9/1/11 indicated the Interdisciplinary Team (IDT) met and agreed to remove dangerous objects out of the apartment (pens, pencils, bats, knives, forks, spoons replaced with plastic ones). The sharp knives were taken out of everyone's apartments. The behavior plan for client #3 dated 6/23/11 was reviewed but no changes were made. The decision was made to add a monitor to the common area of the apartment. The 9/1/11 Social Services report indicated client #4 had a</p>				

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	<p>lock on her bedroom door.</p> <p>The Neglect, Abuse, Mistreatment and Exploitation of Residents Policy dated 5/2011 was reviewed on 10/17/11 at 3:30 PM. The policy defined neglect as "knowingly placing a resident in a situation that may endanger his/her life or health, abandoning or cruelly confining a resident of necessary support including food, clothing, shelter or medical care. Failure to provide goods or services to avoid physical harm."</p> <p>Interview with staff #2, Home Manager (HM) on 10/19/11 at 1:30 PM indicated client #3 and client #4 have had problems in the past. Staff #2, HM indicated client #4 would stay in someone else's apartment or staff would stay in the apartment with clients #3 and #4. Staff #2, HM indicated the monitor was used to ensure there were no problems in client #3 and #4's apartment. Staff #2 indicated there was only one staff working at night. Staff #2, HM, indicated there had not been any problems since the monitor had been added. Staff #2 indicated if there wasn't anyone in the office during the day and if the night staff was assisting another client or in another apartment, the monitor could not be heard.</p> <p>9-3-2(a)</p>				

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W0189	<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. Based on observation and interview for 3 of 4 sample clients (clients #2, #3 and #4) and 2 additional clients (clients #7 and #8), the facility failed to ensure the staff assisting with the medication pass was sufficiently trained to check the Medication Administration Record (MAR) with the bubble pack holding the medication.</p> <p>Findings include:</p> <p>During the observation period on 10/18/11 from 6:15 AM to 8:05 AM, the morning medication pass started at 6:30 AM. Client #8 came to the medication room at 6:30 AM. Client #8 read the MAR page and then read the bubble pack. Client #8 did not compare the bubble pack to the MAR page. Staff #3 did not look at the MAR page or the bubble pack. Client #7 came to the medication room at 6:50 AM. Client #7 read the MAR page and then read the bubble pack. Client #7 did not compare the MAR page to the bubble pack. Staff #3 did not compare the bubble pack to the MAR page. Staff #3 did not look at the bubble pack or the MAR page. Clients</p>	W0189	<p>The group home manager reviewed with staff the appropriate protocol during medication passes. Additionally, the manager has explained the procedures for storing medications and refills.</p> <p>To protect other clients: Both the staff and the clients will discuss with the group home manager about comparing the medication bubble pack and the Medical Administration Records (MAR). Doing so will ensure that the client has the correct medication and dosage. Additionally, the procedure for storing medication and refills will be discussed.</p> <p>To prevent recurrence: The group home manager will ensure that the MAR and bubble pack state the same drug name (rather than the trademark name in one place and the generic name in another). The group home manager and staff will assess the MAR for all residents to ensure accuracy with the doctor and pharmacy orders.</p> <p>Quality assurance: The group home manager will observe medication passes on a monthly basis to ensure compliance with all medication pass protocol.</p>	11/29/2011	

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	<p>#2, #3 and #4 followed the same procedure. Clients #2, #3 and #4 each read the MAR and would then read the bubble pack. They did not compare the bubble pack against the MAR. Staff #3 did not look at the MAR or the bubble pack.</p> <p>Client #3 came to the medication room at 7:15 AM on 10/18/11 and took her med box out of the locked medicine cabinet. Client #3 unlocked her medication box and started reading the bubble packs. Client #3 stopped reading the one for Omeprazole, 20 mg (milligrams) for acid reflux and indicated to staff #3 that the bubble pack wasn't hers. Client #3 indicated the bubble pack had client #4's name at the top. Staff #3 looked at the bubble pack and agreed with client #3 and said the pharmacy must have made a mistake. Staff #3 looked in the drawer where extra meds were kept and indicated there wasn't any Omeprazole in there for her. Staff #3 gave the bubble pack back to client #3 and told her it was the same thing she took and to go ahead and take this one and they would have the pharmacy run a new label with her name on it. Staff #3 did not check the Medication Administration Record (MAR) at any time while looking for client #3's bubble pack.</p>		Responsible party: Group home manager		

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	<p>Review of the MAR dated 10/1/11 through 10/31/11 was conducted on 10/18/11 at 8:30 AM. The MAR indicated client #3 was to receive Omeprazole, 40 mg at the 7:00 AM medication pass. Interview with staff #3 at 8:00 AM indicated she had looked for a 20 mg tablet instead of the 40 mg. Staff #3 indicated she did not know the dosage had changed for client #3. Staff #3 looked in the medication drawer and found a bubble pack with client #3's name containing the 40 mg of Omeprazole that was the correct amount. Staff #3 indicated she had looked for the 20 mg tablet and didn't check the names on the bubble packs.</p> <p>Interview with staff #3 on 10/18/11 at 8:00 AM indicated clients #2, #3, #4, #7 and #8 are learning to pass their own medication. Staff #3 indicated the clients read the MAR, the bubble pack, and pop the medication out of the bubble pack. Staff #3 indicated she did not check the bubble pack against the MAR page. Staff #3 indicated she did make sure the clients took the medication after popping it out of the bubble pack.</p> <p>Interview with staff #2 Home Manager (HM), on 10/19/11 at 1:30 PM indicated the staff assisting with the medication administration is supposed to ensure the</p>						

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W0323	<p>clients compare the bubble pack to the MAR page.</p> <p>9-3-3(a)</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on record review and interview for 1 of 4 sampled clients (client #2), the facility failed to ensure a hearing evaluation had been conducted.</p> <p>Findings include:</p> <p>The record review for client #2 was conducted on 10/18/11 at 9:32 AM. The record indicated client #2 had moved into the home in July, 2009. The physical examination for client #2 was conducted 7/18/11 and did not include a hearing evaluation. There was no indication client #2's hearing had been evaluated since she moved into the home.</p> <p>Interview with staff #2, Home Manager (HM), on 10/19/11 at 1:30 PM indicated the hearing evaluation had not been done. Staff #2, HM, indicated the evaluation should have been done.</p>	W0323	<p>Hearing appointments have been scheduled for two clients. At the time of these clients' appointments, all other residents will be scheduled.</p> <p>To protect other clients: The manager will use a spreadsheet of listed time frames for future medical appointments. Hearing appointments are included on the spreadsheet. The manager will use this tool to ensure that appointments for hearing tests are scheduled in a timely manner.</p> <p>To prevent recurrence: Upon arrival to a group home, an initial checklist is reviewed. Included on this checklist is hearing evaluations. Additionally, group home managers complete a spreadsheet for medical appointments for the residents in their home. This sheet is sent to the Residential Director for review. A copy is also sent to the Residential Nurse. The manager</p>	11/29/2011	

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W0369	<p>9-3-6(a)</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 on observation, record review and interview for one of 26 doses of medication administered, the facility failed to ensure the correct dosage was administered to client #3.</p> <p>Findings include:</p> <p>The morning medication administration was observed on 10/18/11 at 6:30 AM. Client #3 came to the medication room at 7:15 AM and took her med box out of the locked medicine cabinet. Client #3 unlocked her medication box and started reading the bubble packs. Client #3</p>	W0369	<p>will refer to this sheet throughout the year to ensure that appointments are made in a timely manner. The Interdisciplinary Team (IDT) will also review hearing tests at the annual case conference for each client.</p> <p>Quality Assurance: Hearing tests will be added to the checklist used at annual case conferences to ensure that the topic is addressed and hearing tests have been performed.</p> <p>Responsible parties: The IDT, Home Manager, and Residential Nurse.</p> <p>The group home manager reviewed with staff the appropriate protocol during medication passes. Additionally, the manager has explained the procedures for storing medications and refills.</p> <p>To protect other clients: Both the staff and the clients will discuss with the group home manager about comparing the medication bubble pack and the Medical Administration Records (MAR). Doing so will ensure that the client has the correct medication and dosage. Additionally, the procedure for storing medication and refills will be discussed.</p>	11/29/2011	

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	<p>stopped reading the one for Omeprazole, 20 mg (milligrams) for acid reflux and indicated to staff #3 that the bubble pack wasn't hers. Client #3 indicated the bubble pack had client #4's name at the top. Staff #3 looked at the bubble pack and agreed with client #3 and said the pharmacy must have made a mistake. Staff #3 looked in the drawer where extra meds were kept and indicated there wasn't any Omeprazole in there for her. Staff #3 gave the bubble pack back to client #3 and told her it was the same thing she took and to go ahead and take this one and they would have the pharmacy run a new label with her name on it. Staff #3 did not check the Medication Administration Record (MAR) at any time while looking for client #3's bubble pack.</p> <p>Review of the MAR dated 10/1/11 thru 10/31/11 was conducted on 10/18/11 at 8:30 AM. The MAR indicated client #3 was to receive Omeprazole, 40 mg at the 7:00 AM medication pass. Interview with staff #3 at 8:00 AM indicated she had looked for a 20 mg tablet instead of the 40 mg. Staff #3 indicated she did not know the dosage had changed for client #3. Staff #3 looked in the medication drawer and found a bubble pack with client #3's name containing the 40 mg of Omeprazole that was the correct amount. Staff #3 indicated she had looked for the</p>		<p>To prevent recurrence: The group home manager will ensure that the MAR and bubble pack state the same drug name (rather than the trademark name in one place and the generic name in another). The group home manager and staff will assess the MAR for all residents to ensure accuracy with the doctor and pharmacy orders.</p> <p>Quality assurance: The group home manager will observe medication passes on a monthly basis to ensure compliance with all medication pass protocol.</p> <p>Responsible party: Group home manager</p>		

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W0436	<p>20 mg tablet and didn't check the names on the bubble packs.</p> <p>Interview with staff #2, Home Manager (HM), on 10/18/11 at 8:45 AM indicated the staff was supposed to check the MAR with the bubble pack before administering any medication. Staff #2, HM, indicated she did not know how client #4's bubble pack for Omeprazole got in client #3's medication box.</p> <p>9-3-6(a)</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review and interview for 1 of 4 sample clients (client #4), the facility failed to provide training to assist the client with learning to wear eye glasses.</p> <p>Findings include:</p> <p>During the observation period on 10/17/11 from 4:15 PM to 7:00 PM, client #4 was observed sitting on the patio at 4:30 PM without glasses. Client #4 did not wear glasses at any time during the observation period.</p>	W0436	<p>The QMRP now has a formal goal in place for client 4 to wear the prescribed glasses at all times. Staff have been trained on implementing this goal and regularly prompt client 4 to wear glasses throughout the day.</p> <p>To protect other clients: All clients will be assessed for any adaptive device requirements. The devices will be reviewed to ensure they are fully functioning. In the event that a device breaks, a backup will be available.</p> <p>To prevent recurrence: The group</p>	11/29/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G611	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/27/2011
NAME OF PROVIDER OR SUPPLIER BLUE RIVER SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 281 MCGRAIN ST CORYDON, IN47112		
(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 record review for client #4 was conducted on 10/18/11 at 2:26 PM. The record indicated she had an eye examination done on 10/12/10. The medical report indicated client #4 received a prescription for glasses and indicated the glasses should be worn full time.</p> <p>Interview with staff #2, Home Manager (HM), on 10/19/11 at 1:30 PM indicated client #4 had glasses, but she refused to wear them. Staff #2, HM, indicated they did not have a training program for her to wear the glasses.</p> <p>9-3-7(a)</p>		<p>home manager will ensure that all doctor's orders are filed and available to staff. Upon receiving orders for adaptive devices, the resident and group home manager will immediately obtain the device. The QMRP will create a documentation sheet to baseline the clients' use of their adaptive devices. If the client does not use the device per doctor's orders, a formal goal to do so will be implemented.</p> <p>Quality assurance: The QMRP will discuss adaptive devices at each client's annual case conference to ensure that the devices are fully functioning.</p> <p>Responsible party: QMRP</p>		