

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G289	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/13/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BLUE RIVER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 75 EAST OAK DR SALEM, IN 47167
---	--

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

W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: February 11, 12 and 13, 2014.</p> <p>Surveyor: Dotty Walton, QIDP.</p> <p>Facility Number: 000808 AIM Number: 100385640 Provider Number: 15G289</p> <p>These deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/20/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000210	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN 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. Based on observation, record review and interview for 1 of 4 sampled clients (#1), the facility failed to ensure the client's assessments included oral motor (chewing and swallowing abilities) skills.</p>	W000210	<p>W210An oral motor skill assessment will be given to client #1 by the dietician and recommendations will be implemented.To protect other clients: Any new client will be referred to the dietician, by the home manager, to be given an</p>	03/15/2014

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: 15G289	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/13/2014
NAME OF PROVIDER OR SUPPLIER BLUE RIVER SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 75 EAST OAK DR SALEM, IN 47167		
(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>Findings include:</p> <p>Client #1 was observed during the evening meal on 2/11/14 from 4:30 PM until 5:00 PM. Client #1 ate her meal of crockpot prepared beef and vegetables in a fast manner, taking multiple (two to four) bites of food prior to chewing and swallowing. Client #1 was offered cheese as a substitute for her unwanted milk serving. Client #1 dropped some of the soft cheese onto her plate from her mouth; client #1 did not continuously close her mouth while chewing.</p> <p>Review of client #1's record on 02/13/14 at 10:00 AM indicated the client was admitted to the facility on 10/22/13. Client #1's record contained an Occupational Therapy/OT evaluation dated 11/06/13 and a Speech/Hearing (SH) evaluation dated 11/07/13. The evaluations did not contain information about client #1's oral motor (chewing/swallowing skills). The record review also indicated a dietary assessment dated 10/30/13. Review of the assessment indicated no evidence the registered Dietitian had watched client #1 eat a meal so the client's oral motor skills could be evaluated.</p> <p>Interview (February 13, 2014 at 11:55 AM) with House Manager #1, who</p>		<p>oral motor skill assessment, upon moving in the home. All recommendations will be implemented. To prevent recurrence: The home manager will coordinate new clients' appointments with dietician to have an oral motor skill assessment given upon admittance to the facility. All recommendations will be implemented. Quality assurance: A checklist listing all required assessments will be prepared by the IDT at the move in conference. This checklist will include an oral motor skill assessment. This assessment will be reviewed at the 30-day conference with the IDT team and again at the annual conference. The team will ensure that all recommendations are implemented for each client. Responsible parties: Home manager and IDT team</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G289	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/13/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BLUE RIVER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 75 EAST OAK DR SALEM, IN 47167
---	--

(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
W000331	<p>coordinated clients' evaluation/assessment appointments, indicated client #1's oral motor skills had not been included in her initial assessments after her admittance to the facility.</p> <p>9-3-4(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 1 of 4 sampled clients (#1), the facility's nursing services failed to ensure the client's possible thyroid condition was assessed.</p> <p>Findings include:</p> <p>Review of client #1's record on 02/13/14 at 10:00 AM indicated the client had been admitted to the facility on 10/22/13. The record contained a copy of client #1's most recent vision evaluation dated 4/30/13, done prior to her admittance. The vision exam indicated "thyroid disorder-medical</p>	W000331	<p>W331Client # 1 will see her physician for an assessment of a possible thyroid condition. The Home Manager will follow all recommendations of the physician. To protect other clients and prevent recurrence: The Home Manager will follow up on all medical recommendations for new clients. The recommendations may be from medical records, observation or incoming medical examination. The Home Manger will schedule all recommended assessments and follow up on all medical recommendations. The Nurse will review each client's chart at least monthly to review all recommendations and</p>	03/15/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G289		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/13/2014	
NAME OF PROVIDER OR SUPPLIER BLUE RIVER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 75 EAST OAK DR SALEM, IN 47167			
(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>management is maintained." A review of client #1's medications (physician's orders dated 12/5/13) indicated no treatment for a thyroid disorder. The initial assessment by the consulting pharmacist date 11/1/13 recommended a "Thyroid Panel (blood testing of thyroid hormone)." Client #1's record contained an initial nursing assessment by RN #1 on 10/22/13. The RN had noted there was a question as to whether client #1 had a thyroid condition or not. The RN had recommended thyroid testing. There was no more documentation in the client's record to indicate the RN had followed-up on her initial recommendation for thyroid testing since 10/22/13.</p> <p>Interview (February 13, 2014 at 11:55 AM) with House Manager #1, who coordinated clients' evaluation/assessment appointments, indicated client #1's thyroid testing had not been accomplished. The interview indicated the RN assessed each client's needs and made recommendations which were to be carried out by the HM and the group home staff who coordinated the clients' appointment schedules. HM #1 indicated she had asked the physician to order the thyroid laboratory screening, but the order had not been written. The interview</p>		<p>corresponding follow up. The Nurse will ensure that all recommended tests and care instructions are implemented. Quality assurance: A checklist listing all required assessments will be prepared by the IDT at the move in conference. All assessments will be reviewed at the 30-day conference with the IDT team and again at the annual conference. The team will ensure that all recommendations are implemented for each client. Responsible parties: Home Manager, Nurse and IDT.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G289	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/13/2014
NAME OF PROVIDER OR SUPPLIER BLUE RIVER SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 75 EAST OAK DR SALEM, IN 47167		
(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	
	indicated neither the RN nor the HM had realized the testing had not been done. 9-3-6(a)				