

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G642	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/28/2012
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NAME OF PROVIDER OR SUPPLIER  BLUE RIVER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1365 MARVY LN PALMYRA, IN 47164
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W0000	<p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>Dates of Survey: November 26, 27, and 28, 2012.</p> <p>Surveyor: Dotty Walton, Medical Surveyor III</p> <p>Facility Number: 001109 AIM Number: 100240270 Provider Number: 15G642</p> <p>The following deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/5/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		

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

TITLE

(X6) DATE

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

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W0157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on observation, record review and interview for 1 of 6 investigations reviewed (client #4), the facility failed to implement corrective action (non skid socks/footwear) which had been taken regarding client #4's falls.</p> <p>Findings include:</p> <p>Review of facility investigations and follow up reports on 11/26/12 at 1:30 PM indicated a report dated 2/29/12 concerning client #4 sustaining an injury as a result of a fall. The injury was investigated and the interdisciplinary team met on 3/5/12 to discuss remedies to the client's falling. A recommendation was made for client #4 to wear non-skid type socks if he was not wearing shoes while at home. The RN had revised his care plan which addressed his diagnosis of cerebral palsy to include the use of non skid socks to address falls.</p> <p>During observations at the facility on 11/26/12 from 4:00 PM until 6:30 PM, client #4 wore regular socks with no shoes. On 11/27/12 at 7:05 AM, client #4 entered the medication room and fell over a chair. Client #4 was wearing regular sock without shoes. Client #4 did not</p>	W0157	<p>Since the falls suffered by client #4 are not a result of skidding, the interdisciplinary team will immediately review and revise the client's care plan.</p> <p>To protect other clients: A staff meeting at the group home is scheduled to review the fall risk plans for all clients. Any necessary changes to the plans will be made at this time.</p> <p>To prevent recurrence: All care plans are reviewed in the event of a fall or other health-related incident. Additionally, all care plans are reviewed annually at each clients' case conference, at which time changes are made if necessary.</p> <p>Quality compliance: The nurse revises care plans and files them as needed. The QMRP assures that the updated plans are read and signed by staff and filed in the group home within thirty days of the case conference.</p> <p>Responsible party: Group home manager, nurse.</p>	12/28/2012			

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	<p>wear non-skid type socks in either observation.</p> <p>Interview with staff #4 on 11/27/12 at 4:30 PM indicated client #4 would remove his shoes and had to be redirected not to throw them in the trash. The interview indicated he had issues with balance and falls due to the effects of his cerebral palsy.</p> <p>9-3-2(a)</p>				

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W0189	<p>483.430(e)(1) STAFF TRAINING PROGRAM 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 observation, record review and interview for 2 of 2 sampled clients (clients #1 and #2), and 2 additional clients (#3 and #4), the facility failed to ensure direct contact staff were trained to evacuate clients in time of emergency and were trained to fill out incident/accident reports when clients fell (client #4).</p> <p>Findings include:</p> <p>1. Review of facility investigations and follow up reports on 11/26/12 at 1:30 PM indicated a report dated 6/11/12 concerning client #4 being unable to bear weight on his feet on 6/11/12 at 7:00 AM. He was sent for evaluation and diagnosed with a sprained left ankle. The incident report follow-up report dated 6/18/12 indicated staff reported client #4 had fallen after he "jumped up" from the dinner table on 6/10/12 and limped for 30 seconds before running down the bedroom hall. Additional review of incident reports on 11/27/12 at 8:00 AM indicated no incident report regarding client #4's 6/10/12 fall.</p>	W0189	<p>Staff will meet to review evacuation procedures and how to properly document incident reports. An incident report will be completed for client #4 since no report was done at the time of the event.</p> <p>To protect other clients and prevent recurrence: A staff meeting is scheduled to review evacuation procedures and documentation and how to properly complete incident reports. During this meeting, staff will be provided with examples of what and what not to document. Additionally, staff is trained on the general rules of evacuation drills at orientation upon hire. The first drills the new hire conducts are under the supervision of an experienced staff.</p> <p>Quality compliance: The home manager reviews incident reports and drill documentation to ensure adequacy.</p> <p>Responsible party: Group home manager.</p>	12/28/2012			

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	<p>Interview with staff #3 on 11/27/12 at 3:30 PM indicated there was no incident report made by direct contact staff who witnessed client #4 falling the evening of 6/10/12 but there should have been.</p> <p>2. During observations at the facility on the afternoon of 11/27/12 from 3:30 PM until 7:45 PM the facility's oven caught on fire at 5:10 PM. Staff #2, #4, and #5 were assisting clients #1, #2, #3, and #4 with the evening meal and staff #4 turned on the self cleaning feature of the facility's oven. Client #4 had returned to his bedroom and clients #1, #2, and #3 were at the dining table in the kitchen area. The oven began to smoke and staff #4 opened it wherein it began to flame. Staff #2 was getting ice cream and fruit for clients and staff #4 and #5 were discussing whether to use salt or flour to control the oven flames. The staff did not immediately direct the clients to evacuate the facility when the oven started to smoke/burn.</p> <p>During an interview with staff #1 on 11/27/12 at 6:00 PM, staff #1 stated staff were to evacuate clients "immediately" when emergency situations arose (oven fire).</p> <p>9-3-3(a)</p>				

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W0368	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 1 of 2 sampled clients (#2), the facility failed to ensure client #2 received her medication as prescribed by the physician.</p> <p>Findings include:</p> <p>Review of reportable incidents was done on 11/26/12 at 1:30 PM and indicated the following medication error reported on 8/16/12: Client #2 was prescribed amoxicillin (antibiotic) 4 tablets of 500 milligrams the night before dental procedures. Staff #2 administered 4 Vitamin D capsules to client #2 on 8/14/12 instead of the antibiotic pills.</p> <p>Review of client #2's record on 11/27/12 at 6:30 PM indicated she was to receive an antibiotic prior to dental procedures to minimize the possibility of infection due to her diagnosis of mitral valve prolapse.</p> <p>Interview with staff #4 on 11/27/12 at 7:20 AM indicated client #2 received antibiotics prior to dental procedures and vitamin D capsules were prescribed on a weekly basis.</p>	W0368	<p>A staff meeting has been scheduled to address drugs are administered in compliance with physician's orders. Additionally, the group home manager will observe each staff to ensure that they are following the appropriate procedures.</p> <p>To protect other clients and prevent recurrence: A staff meeting will be held during which time the nurse will review the procedures for administering medication with staff. Additionally, staff is trained upon hire in how to administer medication. To ensure compliance with these procedures, the home manager will observe all staff as they administer medication in addition to observing each staff at least once per month thereafter to ensure compliance with medication pass procedures. In the event a medication error occurs, the standard procedures for reporting the error will be made and corrective actions will be taken. Last, the group home manager will review the process of reporting a medication error in the event that one occurs.</p> <p>Quality compliance: The group home manager will observe</p>	12/28/2012			

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	9-3-6(a)		medication administration by staff and always reviews any reports of medication errors.  Responsible party: Group home manager, nurse.		

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W0448	<p>483.470(i)(2)(iv) EVACUATION DRILLS</p> <p>The facility must investigate all problems with evacuation drills, including accidents. Based on record review and interview for 2 of 2 sampled clients (#1 and #2), and 3 additional clients (#3, #4, and #5), the facility failed to investigate issues noted during evacuation drills.</p> <p>Findings include:</p> <p>A review of the facility's evacuation drills with clients #1, #2, #3, #4 and #5 was conducted on 11/27/12 at 5:00 PM and indicated the following:</p> <p>-On 01/07/12 at 12:00 PM an evacuation drill was conducted lasting 3 minutes and 46 seconds. The drill form indicated 3 staff assisted clients #1, #2, #3, #4, and #5. There was no documentation regarding the level of assistance clients needed to exit the facility.</p> <p>-On 01/18/12 at 7:30 PM, an evacuation drill was conducted lasting 2 minutes and 10 seconds. Three staff assisted clients #1, #2, #3, #4, and #5 during the drill. Client #3 refused to evacuate. There was no documentation of the prompt levels required to get clients to evacuate. Client #3's refusal had not been investigated.</p> <p>-On 02/10/12 at 10:15 PM, an evacuation drill was conducted lasting 4 minutes and 30 seconds with one staff and clients #1,</p>	W0448	<p>Staff will meet to review evacuation procedures and how to properly document these procedures. Specific problems will be addressed and a target time limit for each resident to vacate during a drill will be set.</p> <p>To protect other clients and prevent recurrence: A staff meeting is scheduled to review evacuation procedures and how to properly complete the documentation for the evacuation. During this meeting, staff will be provided with examples of what and what not to document. The home manager will have staff begin documenting the level of assistance required for each resident during the drill (for example, "physical assistance required," or "verbal prompt required"). Additionally, staff is trained on the general rules of evacuation drills at orientation upon hire. The first drills the new hire conducts are under the supervision of an experienced staff.</p> <p>Quality compliance: The home manager reviews drill documentation to ensure adequacy.</p> <p>Responsible party: Group home manager</p>	12/28/2012			

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	<p>#2, #3, #4, and #5. The drill form indicated client #3 yelled loudly enough to awaken the neighbors. There was no documentation the prompt levels required for the clients.</p> <p>-On 03/10/12 at 1:00 PM evacuation drill was conducted lasting 5 minutes and 30 seconds with one staff and clients #1, #2, #3, #4, and #5. The drill form indicated clients #1 and #2 were slow to exit the facility and client #4 wanted to go back inside. There was no documentation of the level of assistance required for each client to exit the facility.</p> <p>-On 04/03/12 at 8:35 PM, an evacuation drill lasting 2 minutes and 45 seconds was conducted with one staff and clients #1, #2, #3, #4, and #5. The drill form indicated clients #1 and #2 were "very, very slow" to exit. There was no documentation of the level of assistance required for each client to exit the facility.</p> <p>-On 06/11/12 at 9:30 PM, an evacuation drill lasting 5 minutes and 24 seconds was conducted with two staff and clients #1, #2, #3, #4, and #5. The drill form indicated clients #1 and #3 were asleep and refused to exit. There was no documentation of the level of assistance required for each client to exit the facility. There was no investigation of the refusals.</p> <p>-On 09/12/12 at 11:30 PM, an evacuation drill lasting 5 minutes and 30 seconds was conducted with one staff and clients #1,</p>						

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	<p>#2, #3, and #4. There was no documentation of the level of assistance required for each client to exit the facility. There was no investigation regarding the evacuation time length.</p> <p>Interview with staff #4 and #5 on 11/27/12 at 4:20 PM indicated clients #1, #2, and #3 sometimes refused or took an extended length of time to evacuate the building during drills. Client #4 would evacuate but head back inside if not redirected. The interview indicated the documentation of the length of the drill was the time it took the slowest client to evacuate. Individual times or prompt levels for each client were not documented.</p> <p>An interview with staff #1 on 11/27/12 at 6:00 PM indicated the facility conducted evacuation drills but a targeted time for evacuation had not been determined.</p> <p>9-3-7(a)</p>			