

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G468	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/19/2014
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NAME OF PROVIDER OR SUPPLIER BLUE RIVER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5771 E SPEED RD MILLTOWN, IN 47145
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W000000	<p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>Dates of Survey: November 17, 18, and 19, 2014.</p> <p>Facility number: 000982 Provider number: 15G468 AIM number: 100385530</p> <p>Surveyor: Dotty Walton, QIDP.</p> <p>These federal deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/2/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview, the governing body failed to exercise operating direction over the facility to provide a safe and clean environment for 5 of 5 clients (#1, #2, #5, #6, and #7) living in the group home.</p> <p>Findings include:</p>	W000104	<p>W104 A meeting between the Residential Manager, the Residential Director and the Properties Manager took place to identify corrective measures for the general policy, budgeting, and operating deficiencies. For the failure to ensure good repair of living room and bedroom carpets, painted walls, and dining room</p>	12/19/2014

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.

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	<p>Observations of clients #1, #2, #5, #6, and #7 (at the group home) were done on 11/17/14 from 4:30 PM to 6:00 PM and on 11/18/14 from 6:00 AM until 7:35 AM. The observations included the following environmental conditions: the entryway and front hallway walls had mismatched paint areas. The living room carpet had a stain in front of the couch. The dining room chairs were mismatched; the wooden ones' finish was faded, and the vinyl chairs had torn seats. The bathroom in the bedroom hallway had a loud sounding exhaust fan, the tiles in front of the tub were cracked and the baseboard around the tub was discolored and in need of repair. Client #2's bedroom carpeting had a ripped seam area.</p> <p>Interview with staff #1 on 11/19/14 at 11:00 AM indicated the environmental issues should be referred via work orders to the administration for action.</p> <p>9-3-1(a)</p>		<p>furniture, bathroom exhaust fan, bathroom tiles and baseboards, the property manager will schedule repainting, repairing or replacing all of the environmental issues listed as necessary. To Protect Other Clients and Prevent Recurrence: Each Residential Manager will ensure proper upkeep on all environmental aspects of the group home by completing a Monthly Maintenance Checklist. The manager will visually inspect the home and list any needed repairs. Any needed repairs will be sent to the Properties Manager who schedules all repairs for the agency. Residential staff will report any maintenance items that need attention to the Residential Manager on a daily basis by verbal report, through email or via the established written communication system for that facility. The Residential Manager will then either repair the item or notify the Properties Manager of the repairs needed via email. This email will also be forwarded to the Residential Director. The Residential Manager will repair or replace any minor maintenance items. If the repair requires a professional repairman the manager will notify the Properties Manager. This procedure will aslo apply to the repalcement of costly items. he Properties Manager will schedule reapaers or assist in the replacement of items upon</p>		

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W000249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has		notification of that item. The Residential Director will follow up with the Residential Manager and Properties Manager to ensure that each item has been addressed in a timely manner. Additionally the Residential Manager will do a visual check of the facility each time they are at that site. This does not mean the manager will check each area of the facility but merely to notice any items that need attention by observing the general function of the home. The thorough visual check is done during the monthly inspection. The manager will notify the Properties Manager and Residential Director as described above if any repairs are discovered in day to day work at the home. Quality assurance: Each Residential Manager will send the completed Monthly Maintenance Checklist to the Residential Director at the end of every month. The Residential Director or a designee will review each checklist and follow up on all needed repairs to ensure that they are completed. If any repairs are not completed the Residential Director will contact the Properties Manager to schedule repairs immediately. Responsible parties: Properties Manager, Residential Manager, and Residential Director.		

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	<p>formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review and interview for 2 of 3 sampled clients (#1 and #2), the facility failed to ensure staff implemented training objectives at times of opportunity.</p> <p>Findings include:</p> <p>Observations of clients #1, #2, #3, #4, and #5 were done on 11/18/14 from 6:00 AM until 7:35 AM. The observations included the morning medication administration. Staff #6 administered client #2's medications at 6:46 AM. No training was provided to client #2. Staff #6 administered client #1's medications at 6:55 AM. No training was provided to client #1.</p> <p>1. Client #1's record was reviewed on 11/19/14 at 10:30 AM. The review indicated an Individual Support Plan/ISP dated 12/05/13. The ISP contained a training objective to identify the purpose of his blood pressure medication.</p> <p>Interview with staff #1 on 11/19/14 at 1:00 PM indicated client #1 took</p>	W000249	<p>W249 A meeting was held by the Residential Manager to retrain all group home staff on implementing all medication training goals with the clients, as stated in the ISPs of the clients. The Residential Manager of this facility will observe each staff while they administer medications to the clients at this facility. The manager will observe staff pass medications to the clients at least three times per week until it is evident that they are working on medication goals during each medication pass. When that has been accomplished the monitoring will be reduced to at least one time per month. To Protect Other Clients and Prevent Recurrence: Each Residential Manager will observe one staff per month while administering medications. Each Manger will complete a checklist to ensure each staff is completing each step in the medication administration procedures including training the clients on their medication goals. If staff does not successfully complete the procedures for a medication pass, retraining or disciplinary action will be implemented as appropriate. Blue River Services</p>	12/19/2014	

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W000455	<p>Lisinopril for blood pressure and staff #6 could have trained on this medication during the morning medication administration.</p> <p>2. Client #2's record was reviewed on 11/19/14 at 12:30 PM. The review indicated an ISP dated 12/05/13. The ISP contained a training objective to learn the six rights of the medication administration.</p> <p>Interview with staff #1 on 11/19/14 at 1:00 PM indicated client #2's medication objective should have been reinforced by staff #6.</p> <p>9-3-4(a)</p> <p>483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation and interview for 2 of 3 sampled clients (#1 and #2), and 3 additional clients (#5, #6, and #7), the facility failed to ensure clients exhibited proper handwashing technique.</p> <p>Findings include:</p>	W000455	<p>medication policy requires staff who have medication errors to be retrained and/ or be subject to disciplinary action. This could include being banned from passing medications to the clients. Quality assurance: The home manager will submit the completed Medication Administration Checklist to the Residential Director each month. The Director will review the checklist and ensure that any recommended training or disciplinary action is completed. Responsible parties: Residential Manager and Residential Director</p> <p>W455 A meeting was held by the Residential Manager to retrain all group home staff on prompting the clients to wash their hands before all meals, meal preparation and medication passes. This was done to prevent and control infections and diseases. The Residential Manager will observe all staff to</p>	12/19/2014			

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	<p>Observations of clients #1, #2, #5, #6, and #7 (at the group home) were done on 11/17/14 from 4:30 PM to 6:00 PM and on 11/18/14 from 6:00 AM until 7:35 AM. The observations included the evening and morning meals. The morning observation included medication administration.</p> <p>At 4:45 PM on 11/17/14, client #2, who was coughing, set the dining table for dinner. He did not wash his hands prior to setting the table for himself and clients #1, #5, #6, and #7. On 11/18/14 at 6:00 AM breakfast was observed with clients #1, #2, #5, #6, and #7. Clients did not wash hands prior to having breakfast.</p> <p>Observations of clients #1, #2, #3, #4, and #5 were done on 11/18/14 from 6:00 AM until 7:35 AM. The observations included the morning medication administration. Staff #6 administered client #2's medications at 6:46 AM. Client #2 did not wash hands prior to his medication administration. Staff administered client #5's medications at 6:50 AM. Client #5 did not, and was not directed to, wash his hands before medications. Staff #6 administered client #1's medications at 6:55 AM. Client #1 did not wash his hands prior to medications. Staff #6 administered client #6's medications at 7:02 AM. Client #6</p>		<p>ensure they are prompting the clients in hand washing techniques. This will occur during the time frame of meals and medication passes. The manager will observe staff pass medications to the clients and during meals at least three times per week until it is evident that they are prompting clients to wash their hands prior to each medication pass and meal. When that has been accomplished the monitoring will be reduced to one time per week. To Protect Other Clients and Prevent Recurrence: The Residential Director will distribute a memo to all Residential Managers regarding infection control. The memo will instruct each manager to complete observations of staff to ensure they are prompting clients to wash hands before all meals, meal preparation and medication passes. Quality assurance: The Residential Manager will observe staff to ensure they are prompting residents to wash hands before meal preparation, while eating and before medication pass. This observation will be done at least once a week. Staff will be retrained as necessary to ensure that they are implementing infection control procedures. Responsible parties: Residential Manager and Residential Director.</p>				

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W000488	<p>did not wash his hands prior to medications. Staff #6 administered client #7's medications at 7:14 AM. Client #7 did not wash his hands prior to medications.</p> <p>Staff #6 was interviewed on 11/18/14 at 7:20 AM. The interview indicated the staff sanitized her hands repeatedly during the medication administration but the clients were not prompted/reminded to wash their hands.</p> <p>Interview with staff #1 on 11/19/14 at 1:00 PM indicated it was expected that clients should sanitize/wash their hands as needed during their routine meal preparation, dining and medications. Proper hygiene should have been reinforced by all staff members.</p> <p>9-3-7(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview for 2 additional clients (#5 and #7), the facility failed to ensure the clients participated in</p>	W000488	W488 The Residential Manager held a meeting with all group home staff on custodial care of the clients. The staff was	12/19/2014

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	<p>meals skills according to their capabilities.</p> <p>Findings include:</p> <p>Observations of clients #1, #2, #3, #4, #5, #6 and #7 were done on 11/17/14 from 4:30 PM to 6:00 PM and on 11/18/14 from 6:00 AM until 7:35 AM. The observations included the evening and morning meals.</p> <p>At 11/18/14 at 6:00 AM, client #6 was preparing french toast for the group breakfast. Client #6 placed French toast onto plates assisted by client #2. Staff #6 poured warm syrup onto the French toast and placed it in front of client #5, who was seated at the dining table. Staff #6 cut up the 2 slices of French toast and added butter to them. Staff #6 did not prompt/assist client #5 to cut up the toast. Client #7 was served French toast in the same manner by staff #6. Staff #6 custodially cut up client #7's French toast without including him in the process.</p> <p>Interview with staff #1 on 11/19/14 at 1:00 PM indicated clients #5 and #7 were capable of assisting with cutting food items if given proper guidance from staff. The interview indicated it was expected that clients be offered training and prompting to be as independent as possible.</p>		<p>retrained on the correct way to assist the clients during meals based on their developmental level. The manager will observe staff during meals at least three times per week until it is evident that they are assisting clients appropriately according to their developmental level. When that has been accomplished the monitoring will be reduced to at least one time per week. To Protect Other Clients and Prevent Recurrence: The Residential Director will distribute a memo to all Residential Managers regarding meals skills training. The memo will instruct each manager to complete observations of staff to ensure they are allowing each client to participate in meals skills according to their capabilities. Quality assurance: The Residential Manager will observe staff at least once a week during meals, to ensure that clients participated in meals skills based on their capabilities. Staff will be retrained as necessary when not implementing meals skills training appropriately. Responsible parties: Home manager and group home staff.</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	9-3-8(a)				