

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012
NAME OF PROVIDER OR SUPPLIER BI-COUNTY SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 423 WIND RIDGE TR BERNE, IN 46711		
(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	
W0000	<p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>This was done in conjunction with the post-certification revisit (PCR) to the PCR to the investigation of complaint #IN00096239.</p> <p>Dates of survey: April 23, 24, 25, 30, and May 1 and 2, 2012</p> <p>Surveyor: Kathy Craig, Medical Surveyor III</p> <p>Facility Number: 000669 Provider Number: 15G132 AIMS Number: 100234280</p> <p>These deficiencies also reflect state findings under 460 IAC 9.</p> <p>Quality Review was completed on 5/4/12 by Tim Shebel, 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G132		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012	
NAME OF PROVIDER OR SUPPLIER BI-COUNTY SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 423 WIND RIDGE TR BERNE, IN 46711			
(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			
W0104	<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, for 2 of 8 clients (clients #2 and #8) who resided in the home, the governing body failed to ensure maintenance needs were addressed.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 4/23/12 from 4:10 PM to 6:30 PM. An orange recliner in the front room that belonged to client #2 had a tear on the left arm with stuffing coming out. A burgundy chair had stuffing coming out of the right side which had a 1/2 foot tear long on the right corner by 1/2 foot belonging to client #8.</p> <p>Interview on 4/24/12 at 12:30 PM with the house manager was conducted. The house manager indicated there was no maintenance request to fix the 2 chairs.</p> <p>9-3-1(a)</p>	W0104	<p>Wind Ridge (WR) Recertification & Licensure Survey Plan of Correction Survey Event ID FB9E11 May 2012</p> <p>W104- Governing Body Bi-County Services, Inc. (BCS) will assure that the governing body exercises general policy, budget and operating direction over the agency. The governing body provides, monitors and revises, as necessary, policies, procedures and operating directions, which ensure the necessary staffing, training resources, equipment and environment to provide consumers with active treatment and to provide for their health and safety.</p> <p>Operating direction as it relates to this survey plan of correction (POC) failed to ensure maintenance needs were addressed for recliners belonging to consumers # 2 & 8 which were in shoddy shape and in need of repair &/or replacement.</p> <p>A) Corrective action and follow-up specific to Consumers #2 & 8: 1. On May 1, 2012, Maintenance Technician</p>	06/01/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012
NAME OF PROVIDER OR SUPPLIER BI-COUNTY SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 423 WIND RIDGE TR BERNE, IN 46711		
(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>assessed work order for two recliners at the group home. Both chairs were found to have fabric and frame damage that was beyond repair with recommendations made to replace both chairs. On May 15 , staff along with consumers #2 & 8 went shopping and selected recliners to replace their damaged ones. These will be delivered to the group home on May 17.</p> <p>2. On May 1, 2012, the Maintenance Technician also assessed wall in the WR living room by where consumer # 8 prefers to sit in his recliner to observe what is going on outdoors in his neighborhood. As the recliner often hits up against the wall due to consumer # 8's moving of the recliner as part of a regular routine &/or for a better view, a chair rail was installed and damage to the wall itself was repaired. Consumer #8's new recliner will be assessed for consideration of options to minimize/prevent potential for future damage of his new recliner &/or wall damage.</p> <p>Persons responsible: Residential Manager (RM) and Maintenance Department</p> <p>Target Completion Date: 6/1/12</p> <p>B) Corrective action as it relates to monitoring practices for assuring operating</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012
NAME OF PROVIDER OR SUPPLIER BI-COUNTY SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 423 WIND RIDGE TR BERNE, IN 46711		
(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>directives relating to group home environment agency wide:</p> <p>1. The Residential Management Check Off Sheet will be revised to include regular checks of environmental issues such as walls, doorways, furniture, carpeting, etc. are in good condition and if needs are noted, RM's will follow through and utilize the BCS Work Request process.</p> <p>2. Training on the Governing Body standard with special emphasis on operating directives relating to group home environment will be completed with all Management Team members at the Residential Management Team meeting scheduled for May 24. This will also include the revised Management Check Off Sheet. Persons Responsible: Program Director (PD); Residential Administrator (RA) and RM's.</p> <p>Target completion date: 6/1/12</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012
NAME OF PROVIDER OR SUPPLIER BI-COUNTY SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 423 WIND RIDGE TR BERNE, IN 46711		
(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	
W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on record review and interview, the facility failed to implement their policy by: not investigating 1 of 1 injury of unknown origin regarding 1 of 4 sampled clients (client #3) and by not taking appropriate corrective action after 1 of 4 sampled clients (client #3) had a pattern of falls.</p> <p>Findings include:</p> <p>Review on 4/24/12 at 11:35 AM of the facility's Incident/Accident reports (I & I) which included the following injury of unknown origin dated 12/13/11: On 12/13/11, when staff was getting client #3 ready for the shower, staff #1 noticed client #3 had two bruises on him, "one on his left breast, and one on the right side of his abdomen. Bruises look old." The nurse indicated on the I & I client #3 had 2 1/2 x 3/4 " light brown bruise to mid abdominal area and had a light brown bruise to his left pectoral area 1/2 x 1/2" area. It indicated no further action was needed. There was no investigation available for review with this incident.</p> <p>Review on 4/23/12 at 2:15 PM of the facility's abuse and neglect/injury illness</p>	W0149	<p>W149-Staff Treatment of Clients</p> <p>The agency must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of consumers.</p> <p>In the interest of clarifying our intent as it relates to Staff Treatment of Clients our response for W149, 154 and 157 will be similar in this corrective action plan. We are <u>committed</u> to addressing the deficiencies of failing to implement the agency Abuse/Neglect policy specifically of assuring services/supports to avoid physical harm; thoroughly investigating injuries of unknown origin (IUO) and taking appropriate corrective action for a pattern of accidents (falls).</p> <p>BCS was found to be deficient in not meeting this standard as evidenced by failing to implement our A/N policy by not investigating an IUO and by not taking appropriate corrective action after consumer #3 had a demonstrated pattern of falls from December 2011 through April 2012.</p>	06/01/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012
NAME OF PROVIDER OR SUPPLIER BI-COUNTY SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 423 WIND RIDGE TR BERNE, IN 46711		
(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>policy dated January, 2011, indicated "All Unknown Injuries will be investigated through the Unknown Injury investigation Protocol to assure consumer protections(s)."</p> <p>Interview on 4/30/12 at 6:20 PM with the Residential Director (RD) was conducted. The RD indicated there was no documentation available to determine the source of the two bruises nor was the unknown injury procedure followed for this I & I report of 12/13/11. The RD indicated there was no investigation done on this injury of unknown origin.</p> <p>Review on 4/24/12 at 11:35 AM of the facility's I & I incident reports was conducted and included the following falls regarding client #3:</p> <p>12/16/11: client #3 fell due to not holding onto his walker and may have hit his head on the chair. He landed half on his back and half on his side. Client #3 obtained a bruise to his right temple;</p> <p>12/20/11: Client #3 fell in the bathroom on his back and buttocks. No injury;</p> <p>1/23/12: Client #3 fell into closet door in laundry room. No injury;</p> <p>1/26/12: Client #3 fell in his bedroom when reaching for a ball of yarn on his bedroom floor and told staff he fell on his left shoulder. Client #3 bumped his right</p>		<p>Understanding that this Recertification and State Licensure Survey was completed in conjunction with a second revisit to Complaint Survey (IN00096239) in October 2011 and January 2012 it is evident that we have not taken all the needed steps to assure that the system in place monitors, responds and corrects concerns as they arise thus allowing for prevention of abuse/neglect/exploitation and violation of rights. We are committed to more closely monitoring and following up (F/U) on internal supports in place to prevent recurrence(s). This is a priority commitment and expectation for management and administrative staff.</p> <p>A) Corrective Action and Follow-up specific to Consumer #3 and WR group home:</p> <p>1.IUO. The agency Injury/Illness (I/I) Report will be used to document any injuries, including those of unknown origin. The I/I Report sections relating to IUO will be filled completely especially noting source of injury section. Direct Care Staff (DCS) writing the I/I will also complete the back of the I/I Report section addressing IUO Investigation. All DCS working with WR consumers will be retrained on thorough documentation of the I/I</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G132		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012	
NAME OF PROVIDER OR SUPPLIER BI-COUNTY SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 423 WIND RIDGE TR BERNE, IN 46711			
(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>side of head. No injury.</p> <p>1/31/12: Client #3 fell and a bowl was broken when he fell. His pinky finger on left hand was cut by the joint.</p> <p>2/4/12: Client #3 got up in a hurry and fell transferring from walker to toilet. No injuries. PT (Physical Therapy) assessment ordered due to an increase in falls.</p> <p>3/6/12: Client #3 was putting his coat on and tripped on the leg of an exercise bike. He hit his head on the right side. No injury.</p> <p>3/21/12: Client #3 fell over trying to take coat off. Small scratch on elbow and he indicated to staff his pinky finger hurt. Small 1/4 x 1/4" bruise to right medial wrist. Scratch to right elbow "approximately" 1/2."</p> <p>3/26/12: Client #3 fell in his bedroom onto his chair when hurrying to bathroom from his bed. Client #3 had a cut on his head and left upper arm, also a red mark on his left upper arm.</p> <p>3/30/12: Client #3 missed the chair while trying to sit down on the kitchen chair and hit the back of his head on the floor. No injury.</p> <p>4/14/12: Client #3 fell by walking too fast and lost his balance. He had a 4 inch scrape on anterior side of right lower forearm.</p> <p>Review on 4/24/12 at 10:35 AM of client</p>		<p>Report with focus on IUO portions by 6/1/12.</p> <p>2.It is the responsibility of the Berne Residential Management Team (RMT) to follow-up on any I/Is with IUO by implementing the IUO Investigation Protocol. This protocol specifies that an RMT member complete the Management Injury of Unknown Origin Investigation Report. This investigation and report will be submitted to the RA within 72 hours of the original I/I being written. The WR RMT will be retrained on thoroughly investigating all IUO's and assuring documentation with recommendations through the Management IUO Investigation report by 5/24/12.</p> <p>3.The RA will review all IUO reports noting closure of the investigation and provide recommendations as needed. The RA writes a monthly IUO Investigation Report identifying findings, trends noted, concerns from previous months, results of investigations and recommendations. This report is provided to RMT's and the Quality Assurance Review Team (QART).</p> <p>4.PATTERN OF FALLS. Consumer #3 had eleven incidents of falls from December 2011 through April 2012. The trend was identified and a Physical Therapy Evaluation was completed by Teri Conrad, PT, on 3/8/12. Her recommendations</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012
NAME OF PROVIDER OR SUPPLIER BI-COUNTY SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 423 WIND RIDGE TR BERNE, IN 46711		
(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>#3's records was conducted. Client #3's Health Risk Plan dated 9/8/11 included a Fall Prevention Plan.</p> <p>Review on 5/1/12 at 5:30 PM of client #3's PT evaluation dated 3/8/12, included recommendations that were not included in his Fall Risk Plan.</p> <p>Interview on 4/30/12 at 6:20 PM with the RD was conducted. The RD stated client #3's Fall Risk plan "will be revised in the near future to address increase in falls in the past few months with input from Direct Care Staff (DCS); PT (Physical Therapist); RN's (Registered Nurses); and management team with administrative input as needed. The RD stated, "We dropped the ball some on looking at revisions to his Fall Risk Plan, although the PT evaluation was very helpful."</p> <p>9-3-2(a)</p>		<p>included changes in consumer #3's Home Exercise Program (HEP), addition of practicing specific actions that will assist in decreasing potential for falls and work toward goal of consistent safe walker use. The QMRP did revise consumer #3's Fall Risk Plan (RP) on 3/22/12 to include recommended "practicing" of actions to decrease potential for falls, however, the original Fall RP dated 9/9/8/11 was also in consumer #3's ISP book thus there was no assurance which plan was being followed, as well as no tracking of documentation ensuring that the "practices" were being implemented. As a result of this survey, several specific steps have been taken to assure consistency of interventions to keep him safe. These are identified in Section A items # 5-15</p> <p>5.The HEP is documented on the MAR/TAR.</p> <p>6.Additional recommendations identified in the PT evaluation are documented on a new Fall Prevention Practices tracking sheet effective 5/4/12.</p> <p>7.Consumer #3's formal goal to use his walker safely was revised and implemented effective 5/15/12 to assure consistent safe walker usage with strategies addressing use of HEP, Fall RP and Fall Prevention Practices to assist with preventing falls and his safety.</p> <p>8.Fall RP was revised 5/15/12</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012
NAME OF PROVIDER OR SUPPLIER BI-COUNTY SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 423 WIND RIDGE TR BERNE, IN 46711		
(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>to assure that all the Physical Therapists recommendations are included, as well as identifying specific interventions, monitoring, documentation, notification and training information for all staff working with consumer #3. In addition, all of consumer #3's RPs were reviewed and/or revised effective 5/15/12 to assure appropriateness of plans.</p> <p>9.Consumer Specific Training (CST) document for consumer #3 was revised 5/15/12 to address the areas identified above relating to fall prevention.</p> <p>10.Due to the number of falls which have occurred in the bathroom, a specific Bathing Protocol is being developed for consumer #3. This is in addition to staff following the Instructions for Using SureHands Handi-Slings and Lift. This protocol will address consumer #3's safety, while at the same time trying to respect his advocacy for privacy during times in the bathroom setting.</p> <p>11.All staff working with consumer #3 across all settings will be knowledgeable of revisions to goal(s), RP's, CST, Fall Prevention Practices, HEP and any other pertinent information relating to his health, safety and well-being by 6/1/12.</p> <p>12.All staff working with consumer #3 will be retrained on using the I/I Report to document any falls and potential for injuries. The staff person filling out the I/I</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012
NAME OF PROVIDER OR SUPPLIER BI-COUNTY SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 423 WIND RIDGE TR BERNE, IN 46711		
(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>will also complete the Fall Assessment portion on the back of the I/I. This training will be completed by 6/1/12.</p> <p>13.WR RMT will be retrained on completing the management Fall Assessment Review (FAR) upon receiving any I/Is indicating a fall occurred. The FAR identifies whether further assessment &/or F/U is needed and recommendations for preventing falls by 5/24/12.</p> <p>14.The QMRP will be retrained and monitored by RA and Program Director regarding writing, implementing, monitoring and revising RP's, CST's, ISP goals/objectives, BSP's and monthly reviews that are thorough and meet consumer needs. RP training was done on 5/11/12.</p> <p>15.The Administrative Assistant for Quality Assurance (AAQA) is doing a thorough file check on consumer #3 to assist with identifying any areas for revision, documentation and clarification of programming the week of May 14. This will assist the IST in developing and planning for his annual ISP meeting held 6/13/12 and plans being written for implementation effective 7/1/12 to best meet his needs.</p> <p>Persons Responsible: Program Director (PD); RA; and WR RMT.</p> <p>Target Completion Date: 6/1/12</p> <p>B) Corrective Action as it</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012
NAME OF PROVIDER OR SUPPLIER BI-COUNTY SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 423 WIND RIDGE TR BERNE, IN 46711		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>relates to BCS practices agency wide:</p> <p>1.All DCS working with group home consumers across all settings will be retrained on completing I/Is thoroughly including the staff IUO Investigation and Fall Assessment by 6/1/12.</p> <p>2.All RMT's will receive retraining on monitoring of I/Is, completing management IUO Investigation Report and FAR's as per agency protocols by 5/24/12. Additional training for RMT's will include several items targeted by the PD relating to identified A/N priorities from the post-certification revisit (PCR) complaint survey in January 2012. Items targeted by PD are included in the WR POC Training agenda for RMT members, including but not limited to using Home Observations for quality assurance, agency Vision Statement as guideline for standard of quality and A/N policy review. This additional training will occur by 5/24/12.</p> <p>3.Supported Living Management Teams (SLMT) will be retrained on monitoring I/I', completing management IUO Investigation Report and FAR's by 6/1/12. It will be the responsibility of the SLMT members to train their staff on items listed in section B-16.</p> <p>Persons Responsible: PD; RA and RMT's</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BI-COUNTY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 423 WIND RIDGE TR BERNE, IN 46711
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
			Target Completion Date: 6/1/12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G132		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012	
NAME OF PROVIDER OR SUPPLIER BI-COUNTY SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 423 WIND RIDGE TR BERNE, IN 46711			
(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			
W0154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview, the facility failed to investigate 1 of 1 reviewed injury of unknown origin regarding 1 of 4 sampled clients (client #3).</p> <p>Findings include:</p> <p>Review on 4/24/12 at 11:35 AM of the facility's Incident/Accident reports (I & I) which included the following unknown injury dated 12/13/11: On 12/13/11, when staff was getting client #3 ready for the shower, staff #1 noticed client #3 had two bruises on him, "one on his left breast, and one on the right side of his abdomen. Bruises look old." The nurse indicated on the I & I client #3 had 2 1/2 x 3/4 " light brown bruise to mid abdominal area and had a light brown bruise to his left pectoral area 1/2 x 1/2" area. It indicated no further action was needed. There was no investigation available for review with this incident.</p> <p>Interview on 4/30/12 at 6:20 PM with the Residential Director (RD) was conducted. The RD indicated there was no documentation available to determine the source of the two bruises nor was the</p>	W0154	<p>W154-Staff Treatment of Clients The agency must have evidence that all alleged violations are thoroughly investigated. Per the standard guidelines, BCS will assure that all injuries of unknown origin (IUO) and allegations of abuse, neglect, exploitation and violation of consumer rights are investigated. The mechanism that BCS uses to investigate IUO's is the Injury/Illness Report and IUO Protocol. There are two mechanisms for agency investigation into allegations of abuse, neglect, exploitation and violation of rights. These include directives within the agency Abuse/Neglect (A/N) policy and the Procedure for Investigating Suspected Abuse, Neglect, Exploitation or Violation of Individual Rights. BCS is committed to providing comprehensive and thorough investigations, completed in a timely manner and assuring that action is taken for any recommendations made. In addition, documentation will be available to substantiate the investigation process and outcomes. BCS was found to be deficient in this standard as evidenced by failure to investigate an IUO. Our corrective action for this standard (W154) is inclusive</p>	06/01/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012
NAME OF PROVIDER OR SUPPLIER BI-COUNTY SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 423 WIND RIDGE TR BERNE, IN 46711		
(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>facility's Unknown Injury procedure followed for this I & I report of 12/13/11. The RD indicated there was no investigation conducted on this injury of unknown origin.</p> <p>9-3-2(a)</p>		<p>in the W149 tag with one additional corrective action taken. The IUO Protocol was reviewed and revised on 5/17/12 to clarify management and DCS responsibilities when completing the initial Injury/Illness Report. Reference W149 Corrective Action and Follow-up for Consumer #3 and WR group home Section A items 1-3. In addition, Corrective Action as it relates to BCS practices agency wide Section B items 16-18. Persons Responsible: PD, RA and RMT's. Target Completion Date: 6/1/12</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G132		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012	
NAME OF PROVIDER OR SUPPLIER BI-COUNTY SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 423 WIND RIDGE TR BERNE, IN 46711			
(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			
W0157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed for 1 of 4 sampled clients (client #3) by not taking appropriate corrective action after client #3 had a pattern of falls.</p> <p>Findings include:</p> <p>Review on 4/24/12 at 11:35 AM of the facility's I & I incident reports was conducted and included the following falls regarding client #3:</p> <p>12/16/11: client #3 fell due to not holding onto his walker and may have hit his head on the chair. He half landed on his back and half on his side. Client #3 obtained a bruise to his right temple;</p> <p>12/20/11: Client #3 fell in the bathroom on his back and buttocks. No injury;</p> <p>1/23/12: Client #3 fell into closet door in laundry room. No injury;</p> <p>1/26/12: Client #3 fell in his bedroom when reaching for a ball of yarn on his bedroom floor and told staff he fell on his left shoulder. Client #3 bumped his right side of head. No injury.</p> <p>1/31/12: Client #3 fell and a bowl was broken when he fell. His pinky finger on left hand was cut by the joint.</p>	W0157	<p>W157-Staff Treatment of Clients</p> <p>If an alleged violation is verified, appropriate corrective action must be taken.</p> <p>It is the intent of BCS that all violations related to staff treatment of consumers is seriously considered to determine appropriate corrective action. Moreover, that any corrective action taken is reasonably likely to prevent abuse, neglect, exploitation and/or violation of individual rights from recurring.</p> <p>BCS was found to be deficient in this standard as evidenced by failure in taking appropriate actions after consumer #3 demonstrated a pattern of falls from December 2011 through April 2012. Our corrective action for this standard (W157) is inclusive in the W149 tag.</p> <p>Reference W149 Corrective Action and F/U for consumer #3 and the WR group home Section A items 4-15. Reference W149 Corrective Action as it relates to BCS practices agency wide Section B items 16-18.</p> <p>Person's Responsible: PD, RA and RMT's</p>	06/01/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G132		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012	
NAME OF PROVIDER OR SUPPLIER BI-COUNTY SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 423 WIND RIDGE TR BERNE, IN 46711			
(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>2/4/12: Client #3 got up in a hurry and fell transferring from walker to toilet. No injuries. PT (Physical Therapy) assessment ordered due to an increase in falls.</p> <p>3/6/12: Client #3 was putting his coat on and tripped on the leg of an exercise bike. He hit his head on the right side. No injury.</p> <p>3/21/12: Client #3 fell over trying to take coat off. Small scratch on elbow and he indicated to staff his pinky finger hurt. Small 1/4 x 1/4" bruise to right medial wrist. Scratch to right elbow "approximately" 1/2."</p> <p>3/26/12: Client #3 fell in his bedroom onto his chair when hurrying to bathroom from his bed. Client #3 had a cut on his head and left upper arm, also a red mark on his left upper arm.</p> <p>3/30/12: Client #3 missed the chair while trying to sit down on the kitchen chair and hit the back of his head on the floor. No injury.</p> <p>4/14/12: Client #3 fell by walking too fast and lost his balance. He had a 4 inch scrape on anterior side of right lower forearm.</p> <p>Review on 4/24/12 at 10:35 AM of client #3's records was conducted. Client #3's Health Risk Plan dated 9/8/11 included a Fall Prevention Plan.</p>		Target Completion Date: 6/1/12				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G132		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012	
NAME OF PROVIDER OR SUPPLIER BI-COUNTY SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 423 WIND RIDGE TR BERNE, IN 46711			
(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>Review on 5/1/12 at 5:30 PM of client #3's PT evaluation dated 3/8/12, included the following recommendations: He should practice backing up to seats, bed, toilet, etc. and leave his walker in front of him so it is ready for him when he rises again to stand. He should practice walking in his closet and gathering items with the walker in front of him for stability. The fall risk plan of 9/8/11 was not updated to include the above listed recommendations.</p> <p>Interview on 4/30/12 at 6:20 PM with the RD was conducted. The RD stated client #3's Fall Risk plan "will be revised in the near future to address increase in falls in the past few months with input from Direct Care Staff (DCS); PT (Physical Therapist); RN's (Registered Nurses); and management team with administrative input as needed. The RD stated, "We dropped the ball some on looking at revisions to his Fall Risk Plan, although the PT evaluation was very helpful."</p> <p>9-3-2(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G132		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012	
NAME OF PROVIDER OR SUPPLIER BI-COUNTY SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 423 WIND RIDGE TR BERNE, IN 46711			
(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			
W0227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on record review and interview, the facility failed for 1 of 4 sampled clients (client #3) who had a pattern of falls, by not updating his fall risk plan to include recommendations by his PT (Physical Therapist).</p> <p>Findings include:</p> <p>Review on 4/24/12 at 11:35 AM of the facility's I & I incident reports was conducted and included the following falls regarding client #3:</p> <p>12/16/11: client #3 fell due to not holding onto his walker and may have hit his head on the chair. He half landed on his back and half on his side. Client #3 obtained a bruise to his right temple;</p> <p>12/20/11: Client #3 fell in the bathroom on his back and buttocks. No injury;</p> <p>1/23/12: Client #3 fell into closet door in laundry room. No injury;</p> <p>1/26/12: Client #3 fell in his bedroom when reaching for a ball of yarn on his bedroom floor and told staff he fell on his left shoulder. Client #3 bumped his right side of head. No injury.</p>	W0227	<p>W227-Individual Program Plan The IPP states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment.</p> <p>BCS was found to be deficient in this standard as evidenced by not taking appropriate corrective action after consumer #3 had a demonstrated pattern of falls. Specifically that his Fall Risk Plan was not updated to include recommendations by his Physical Therapist (PT).</p> <p>Consumer #3 had eleven falls from December 2011 through April 2012. The pattern was identified and a Physical Therapy Evaluation was completed by Teri Conrad, PT on 3/8/12. Her recommendations included changes in consumer #3's Home Exercise Program (HEP), practicing specific actions to assist in decreasing potential for falls and work toward goal of consistent safe walker use. The QMRP did revise the Fall Risk Plan (RP) on 3/22/12 to include recommended "practicing" of actions to decrease potential for falls, however, the original Fall RP dated 9/8/11 was also in</p>	06/01/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G132		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012	
NAME OF PROVIDER OR SUPPLIER BI-COUNTY SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 423 WIND RIDGE TR BERNE, IN 46711			
(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>1/31/12: Client #3 fell and a bowl was broken when he fell. His pinky finger on left hand was cut by the joint.</p> <p>2/4/12: Client #3 got up in a hurry and fell transferring from walker to toilet. No injuries. PT (Physical Therapy) assessment ordered due to an increase in falls.</p> <p>3/6/12: Client #3 was putting his coat on and tripped on the leg of an exercise bike. He hit his head on the right side. No injury.</p> <p>3/21/12: Client #3 fell over trying to take coat off. Small scratch on elbow and he indicated to staff his pinky finger hurt. Small 1/4 x 1/4" bruise to right medial wrist. Scratch to right elbow "approximately" 1/2."</p> <p>3/26/12: Client #3 fell in his bedroom onto his chair when hurrying to bathroom from his bed. Client #3 had a cut on his head and left upper arm, also a red mark on his left upper arm.</p> <p>3/30/12: Client #3 missed the chair while trying to sit down on the kitchen chair and hit the back of his head on the floor. No injury.</p> <p>4/14/12: Client #3 fell by walking too fast and lost his balance. He had a 4 inch scrape on anterior side of right lower forearm.</p> <p>Review on 4/24/12 at 10:35 AM of client #3's records was conducted. Client #3's</p>		<p>consumer #3's ISP book thus there was no assurance which plan was being followed, as well as no tracking of documentation ensuring that the practices were being implemented. Several revisions to consumer #3's current plans as well as additional plans added to provide consistency of interventions, prevent falls and support his safety and well-being were a result of this survey process.</p> <p>It is the intent of BCS that comprehensive assessments are completed and any identified needs become part of the objectives targeted within each consumers ISP's.</p> <p>A) Corrective Action and Follow-up specific to consumer #3 and WR group home:</p> <p>1. The QMRP with input from RM and DCS working with consumer #3 will complete assessments assuring that they are comprehensive in nature and that identified needs become a part of his Individual Support Plan. Specific assessments to be completed include: a) General Risk Factors Assessment with narrative included to specify needs/concerns to be addressed; b) Sensory, Physical and Environmental Needs Assessment and c) Functional Assessment. The assessments will be completed by 6/1/12 with identified needs addressed and</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G132		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012	
NAME OF PROVIDER OR SUPPLIER BI-COUNTY SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 423 WIND RIDGE TR BERNE, IN 46711			
(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>Health Risk Plan dated 9/8/11 included a Fall Prevention Plan.</p> <p>Review on 5/1/12 at 5:30 PM of client #3's PT evaluation dated 3/8/12, included the following recommendations: He should practice backing up to seats, bed, toilet, etc. and leave his walker in front of him so it is ready for him when he rises again to stand. He should practice walking in his closet and gathering items with the walker in front of him for stability. The fall risk plan of 9/8/11 was not updated to include the above listed recommendations.</p> <p>Interview on 4/30/12 at 6:20 PM with the RD was conducted. The RD stated client #3's Fall Risk plan "will be revised in the near future to address increase in falls in the past few months with input from Direct Care Staff (DCS); PT (Physical Therapist); RN's (Registered Nurses); and management team with administrative input as needed. The RD stated, "We dropped the ball some on looking at revisions to his Fall Risk Plan, although the PT evaluation was very helpful."</p> <p>9-3-4(a)</p>		<p>appropriate corrective action taken.</p> <p>2. The QMRP will be retrained and monitored by the RA &/or PD regarding comprehensive assessments, writing, implementing, monitoring and revising RP's, CST's, ISP goals/objectives, BSP's and monthly reviews that are thorough and meet consumer needs. Retraining will occur by 6/1/12. A review of identified WR consumer's pertinent plans and monthly reviews will be completed over the course of the next 90 days to assure quality and thoroughness.</p> <p>3. Reference W149 Section A items 4-15 for additional corrective action related to consumer #3 and WR group home.</p> <p>B) Corrective Action as it relates to BCS practices agency wide:</p> <p>4. All Management Team members will be retrained on the priority of comprehensive assessments being completed and assuring that needs identified are addressed with appropriate plans, goals/objectives, training, etc. and become a part of consumer ISP's. Retraining will also address the importance of revisions and additions to plans/programming as identified in a timely manner. Training will occur by 6/1/12.</p> <p>5. Reference W149 Section B items 16-18 for additional</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012
NAME OF PROVIDER OR SUPPLIER BI-COUNTY SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 423 WIND RIDGE TR BERNE, IN 46711		
(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>corrective action related to BCS practices agency wide.</p> <p>Person's Responsible: PD, RA and RMT(s)</p> <p>Target Completion Date: 6/1/12</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G132		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012	
NAME OF PROVIDER OR SUPPLIER BI-COUNTY SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 423 WIND RIDGE TR BERNE, IN 46711			
(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			
W0369	<p>483.460(k)(2) DRUG ADMINISTRATION</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, the facility failed to administer 1 or 12 medications without error for 1 of 4 sampled clients (client #1).</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 4/24/12 from 6:00 AM to 7:45 AM. At 7:00 AM, client #1 was given one 100 mcg (micromilligrams) Levothyroxin tablet (for thyroid). Client #1 was given power pudding by staff #2 after he took his medications.</p> <p>Review on 4/24/12 at 9:45 AM of client #1's MAR (Medication Administration Record) dated April 2012 indicated client #1 was to take his Levothyroxin one hour prior to breakfast.</p> <p>Interview on 4/24/12 at 12:30 PM with the house manager was conducted. The house manager indicated client #1 should have taken his Levothyroxin on an empty stomach.</p> <p>Interview on 4/24/12 at 2:00 PM with the nurse was conducted. The nurse indicated</p>	W0369	<p>W369-Drug Administration</p> <p>All drugs, including those that are self-administered, are administered without error.</p> <p>It is the intent of BCS that we meet the standard(s) of drug administration including the expectation that all drugs are administered in compliance with the physician's orders and are administered without error</p> <p>BCS was found to be deficient in this standard as evidenced by failure to administer a medication without error. Consumer #1 was given thyroid medication Levothyroxin with power pudding at the 7 AM medication pass. The MAR indicated consumer #1 was to take this medication one hour prior to breakfast. Due to consumer #1's psychiatric diagnoses, especially related to his obsessive/compulsive disorder focus on food &/or drink can interfere with his activities of daily living (ADL's) and potential for undermining his health & well-being. Agency RN with input from administrative team and Residential Manager contacted his primary care physician to seek clarification for medication orders related to Levothyroxin.</p>	06/01/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012
NAME OF PROVIDER OR SUPPLIER BI-COUNTY SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 423 WIND RIDGE TR BERNE, IN 46711		
(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>staff should have waited an hour after administering client #1's Levothroxin before giving the client power pudding.</p> <p>9-3-6(a)</p>		<p>1. Corrective Action as it relates to consumer #1:</p> <p>1. On 4/24/12 agency RN contacted Dr. Judge, consumer #1's primary care physician (PCP) to clarify orders for Levothyroxin. Dr. Judge indicated that it would not harm consumer #1 to take power pudding with his thyroid medication and that it was also OK to give small amounts of food & liquid within one hour prior to breakfast (between power pudding and breakfast). A doctor's order was received on 4/24/12 indicating the above information and the MAR was changed to indicate PCP authorization for power pudding and small amounts of liquid one hour prior to breakfast.</p> <p>1. Corrective action for BCS practices agency wide:</p> <p>1. All RMT's will assess needs related to any medications with time restrictions associated with food &/or drink that have the potential for error in administration by 6/1/12. Any concerns regarding medications will be discussed with the agency RN's and consultation with PCP's will be assessed by need.</p> <p>2. Agency RN's complete a Medication Pass Observation monthly at each group home. Any recommendations &/or concerns will be addressed prn.</p> <p>3. Retraining on the Six Rights of medication</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012
NAME OF PROVIDER OR SUPPLIER BI-COUNTY SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 423 WIND RIDGE TR BERNE, IN 46711		
(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>administration and use of the Buddy Check system will occur at scheduled RMT meeting on 5/24/12.</p> <p>4. RMT will assure that all residential DCS are retrained on six rights and Buddy Checks by 6/1/12.</p> <p>5. Day Services staff will be retrained on the Six Rights of Medication Administration by 6/1/12.</p> <p>6. All SLMT members will be retrained on the Six Rights and Buddy Checks by 6/1/12. It is the responsibility of the SLMT to train their DCS on the Six Rights and Buddy Checks (where applicable) at the earliest opportunity &/or next scheduled house meetings.</p> <p>The following are safeguards currently in place to assist with expectation that all drugs are administered in compliance with physician's orders and are administered without error:</p> <p>7. All DCS and management are trained by an agency RN on the state mandated drug administration course "Living in the Community" (LIC) Core A & B. In addition, should RMT's, supervisors and medical staff have concerns that DCS need additional training and supports, these will be provided at the earliest opportunity. No DCS will administer medications should there be any question of their capabilities.</p> <p>8. DCS are aware of the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012
NAME OF PROVIDER OR SUPPLIER BI-COUNTY SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 423 WIND RIDGE TR BERNE, IN 46711		
(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>importance of contacting Medical On-Call for any questions and/or clarification regarding medications, changes in orders, etc.</p> <p>9. RM's are responsible to assure that MAR/TAR's include all physicians' orders for medications, treatments and therapies designated per consumer's health care needs. These are to be accurate to include the six rights (right medication; right dose; right consumer; right route; right time and right documentation on MAR) per physician's orders. RM and/or designee check the MAR daily.</p> <p>10. At least once a month a RN checks the MAR/TAR's for accuracy in each group home. This is another safe guard to assist us in finding new and better ways to monitor that medications, therapies and treatments are being administered as ordered. The agency RN review each month at each home, includes but is not limited to the following items:</p> <ul style="list-style-type: none"> · Physicians orders (other health care professionals included) · Actual medications administered (match blister pack and /or other topical, drops, etc with script) · Compare the MAR/TAR with the orders/scripts to assure accuracy · Review the 90-Day Medication Review at least once 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G132	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012
NAME OF PROVIDER OR SUPPLIER BI-COUNTY SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 423 WIND RIDGE TR BERNE, IN 46711		
(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>a week to assure accuracy.</p> <ul style="list-style-type: none"> Check for changes in medications, stop/start dates, holds and NPO's. <p>11. The Human Rights Committee reviews the 90-Day Medication Reviews every other month with focus on drugs and interactions that could be of concern.</p> <p>12. The Quality Assurance Review Team reviews medication errors as a regular agenda item.</p> <p>13. The agency has a Medication Error Review Team (MERT) that addresses concerns as they arise and make determination(s) regarding personnel action, re-training and/or competency testing.</p> <p>Persons responsible: PD, RN's, RA, RMT's and AAQA.</p> <p>Target completion date: 6/1/12</p>		