

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G611	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/05/2015
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NAME OF PROVIDER OR SUPPLIER BLUE RIVER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 281 MCGRAIN ST CORYDON, IN 47112
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W 000 Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: March 2, 3, 4, and 5, 2015.</p> <p>Facility number: 001162 Provider number: 15G611 AIM number: 100385630</p> <p>Surveyor: Dotty Walton, QIDP.</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 3/16/15 by Ruth Shackelford, QIDP.</p>	W 000		
W 356 Bldg. 00	<p>483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. Based on observation, record review and</p>	W 356	<p>W356 A staff meeting willbe held by the</p>	04/04/2015

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>interview for 1 of 4 sampled clients (#2), the facility failed to ensure dental restorations prescribed by the client's dentist were completed (fillings and crowns).</p> <p>Findings include:</p> <p>During observations of the morning routine, client #2 came to the facility's office on 3/3/15 at 7:35 AM and used the bathroom there for brushing her teeth. Staff did not assist or monitor client #2 during the toothbrushing process.</p> <p>Review of client #2's record on 3/3/15 at 10:00 AM indicated the most recent dental examination dated 12/15/14 which was documented on the facility's "Dentist's Orders and Progress Notes" form. The dental hygienist documented client #2's need for better oral hygiene; hygiene was "poor" and there was moderate plaque. There was "lots of decay (throughout) her mouth." "The immediate concern is for teeth #'s (number's) 4 & (and) 5 (sic) they need to be crowned." The dental hygienist indicated in writing she had "talked with the group home manager about this." The form indicated during the next visit the following should be done: "Needs crowns on #'s 4 & 5 and also needs fillings on several other teeth."</p>		<p>correction date, to retrain all staff working at the home. Allstaff will review client #2's oral hygiene goal with the home manager and willbe retrained on monitoring the client during the performance of this goal. Thehome manager has scheduled a dental appointment for client #2 at this time. Thehome manager will carry out all recommendations given from the dentist afterclient #2's dental appointment.</p> <p>To protect other clients: The home manager will review allclients' dental notes to make sure follow ups on all clients' have beencompleted and the home manager will review all clients' appointment schedulesto ensure that the upcoming dental appointments for all clients' have been madeby the correction date.</p> <p>To prevent recurrence: The home manager will continue to reviewall clients' dental records as they occur. All recommendations that are given atthe time of the clients' dental examinations will be followed and appointmentswill be scheduled for any necessary follow up visits at that time. The homemanager will contact the qidp if any goals are needed to be put in place followingthe recommendations from the dental appointment. These goals will be put inplace by one week after the initial recommendations were made.</p> <p>Quality assurance: All dental visits will be reviewed at theclients' case conference with the IDT team present, to ensure that all</p>	

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W 368 Bldg. 00	<p>Interview with staff #7 on 3/3/15 at 7:40 AM indicated staff did not monitor client #2 during toothbrushing although the client came to the facility's office area to brush her teeth.</p> <p>Interview with House Manager/HM #3 was conducted on 3/3/15 at 11:55 AM. The interview indicated no restorations had been completed on client #2's teeth at the time of the survey.</p> <p>9-3-6(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION 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 2 of 4 sampled clients (#2 and #4), and two additional clients (#5 and #8), the facility failed to ensure all medications were administered according to the physicians' orders without error.</p> <p>Findings include:</p> <p>1. Review (3/3/15 8:00 AM) of client #4's 3/15 MAR (Medication</p>	W 368	<p>dentaladvisements were carried out. Responsible parties: Residential Manager, Residential Home Staff,QIDP</p> <p>W368 1.The medication for client #4 was ordered andadministered and is currently in stock at the group home and available fordaily use. Specific procedures for medication refills will be developed forthis facility and all staff will be trained on that procedure. The procedurewill designate who is responsible for ordering medications and follow upprotocol to ensure that the</p>	04/04/2015	

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	<p>Administration Record) indicated client #4 was to receive a benzoyl peroxide facial treatment (acne)twice daily. The 3/15 MAR indicated the client had last received the benzoyl peroxide on the morning of 3/1/15. Client #4's MAR documentation indicated she had run out of the medication or not received the facial medication on the following times and dates: 3/1/15 at 9:00 PM, 3/2/15 7:00 AM and 9:00 PM.</p> <p>On 3/3/15 at 7:15 AM staff #7 indicated client #4's benzoyl peroxide was not available for administration and needed to be ordered from the pharmacy.</p> <p>Review of Bureau of Developmental Disabilities Services/BDDS reports was done 3/2/15 at 2:00 PM and indicated the following medication error reports:</p> <p>2. 12/30/14 BDDS report, on 12/25/14 at 9:00 PM, indicated client #8 was not given his medications of Pravastatin 20 mg/milligrams (for cholesterol), and vitamin C 200 mg by staff #7.</p> <p>3. 12/30/14 BDDS report, on 12/29/14 at 7:00 AM indicated client #5 did not receive her medications of a multi vitamin, Ferrous Glucose 32 mg. (supplement), Fluoxetine 40 mg. (antidepressant), loratadine 10 mg.</p>		<p>medication has been received.</p> <p>2.The staff person involved in this issue wasretrained on the medication administration procedures and has not had any moremedication errors since those listed in the report.</p> <p>3.This medication was not administered due to theclient being ill and throwing up that day. The staff did not follow the correctprocedure of calling the nurse to get approval to skip the medication. Thisperson has been retrained on the correct procedures for approval for anychanges to medication administration routine. There have been no furtherincidents of this kind. All staff will be retrained on the procedures forcalling the nurse which includes calling for approval for medications notgiven.</p> <p>4 & 5. These errors were bothdone by the same staff person. The individual was working too many hours andhad issues with migraine headaches. She has been retrained and receiveddisciplinary action per policy. She has also been restricted to 40 hours perweek maximum. She continues to receive ongoing monitoring and has not had anymore medication administration errors.</p> <p>To protect other clients andprevent recurrence:</p> <p>1.All staff will continue to follow theestablished medication refill procedure to ensure that all</p>		

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	<p>(allergies), metoclopramide 5 mg. (reflux), omeprazole 40 mg (reflux), and topiramate 25 mg (anticonvulsant used for behavior).</p> <p>4. 1/16/15 BDDS report, indicated client #2 did not receive her levothyroxine 50 mcg/micrograms (hormone) from staff #10 on 1/11/15 at 6:00 AM as prescribed.</p> <p>5. Review (12:30 PM 3/4/15) of a BDDS report dated 3/2/15 for client #8 indicated staff #10 had not given client #8 his medications on 3/1/15 at 9:00 PM: Escitalopram 10 mg. (antidepressant), ferrous sulfate 325 mg. (supplement), niacin 500 mg. (for cholesterol), omeprazole 20 mg. (reflux), Vitamin C 250 mg and There-m (supplements).</p> <p>Interview with House Manager #3 on 3/3/15 at 12:00 PM indicated there had been medication errors and staff involved had been retrained.</p> <p>9-3-6(a)</p>		<p>medications are available for administration at all times.</p> <p>2,4,5. The manager will observe staff passing medications at least once per month. The Residential Nurse will also observe at least one medication pass per month. The observer will ensure that staff are following established medication administration protocol. Staff will be required to participate in training or receive disciplinary action as necessary.</p> <p>3. Staff will receive annual retraining on protocol for calling the nurse with a review of the things the nurse must be called about.</p> <p>All Residential staff will be given a refresher training on administering medications annually. The training will include a skills test to measure their understanding and retention of the information.</p> <p>Quality assurance: All medication errors will be reviewed by the Residential Nurse and Residential Director. Retraining and disciplinary action will be initiated as deemed necessary. The Director will ensure that all training is completed and procedures are revised as necessary to minimize medication errors.</p> <p>Responsible parties: Residential Director, Residential Nurse and Residential Manager.</p>		

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W 369 Bldg. 00	<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 for 2 of 32 medications observed affecting 1 of 4 sampled clients (client #4), the facility failed to ensure all medications were administered according to the physician's orders without error.</p> <p>Findings include:</p> <p>Observations of the medication administration were conducted on 3/2/15 from 3:56 PM until 4:06 PM and on 3/3/15 from 6:33 AM until 7:35 AM.</p> <p>Client #4 was given medications by staff #7 at 7:15 AM on 3/3/15. She was given Flonase nasal spray (allergies) by staff #7 and client #4 sprayed 3 sprays into each of her nostrils. Review of the Flonase label indicated two sprays to each nostril was the prescribed dosage. Client #4 did not receive the facial treatment for her acne, benzoyl peroxide. Client #4 was observed to have facial acne during the medication administration.</p> <p>Review (3/3/15 8:00 AM) of client #4's 3/15 MAR (Medication Administration Record) indicated her Flonase dosage</p>	W 369	<p>W369</p> <p>All staff will be retrained on medication administration by the nurse. The medication goal for client #4 was rewritten by the qidp to indicate that client #4 will be verbally supported by staff on how many sprays are to be given to each nostril during medication pass. All staff will be retrained on the revised medication goal at the staff meeting. The medication for client #4's acne was ordered and is now in use. All staff will be retrained on the procedure to audit meds and on the established medication refill protocol.</p> <p>To protect other clients' and prevent recurrence: A written procedure was established for the staff to notify the home manager who will notify the pharmacy when clients' medications need to be reordered. These procedures will be reviewed with all staff by the home manager. Weekly medication audits by staff are in place to track the inventory of the clients' medications and this procedure will also be reviewed by the home manager with all homestaff at the retraining.</p> <p>Quality Assurance: The nurse will observe staff giving medications to the clients once a month. The</p>	04/04/2015
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W 392 Bldg. 00	<p>was to be two sprays to each nostril. Review (3/3/15 8:00 AM) of client #4's 3/15 MAR (Medication Administration Record) indicated client #4 was to receive a benzoyl peroxide facial treatment twice daily.</p> <p>On 3/3/15 at 7:15 AM staff #7 indicated client #4's benzoyl peroxide was not available for administration and needed to be ordered from the pharmacy.</p> <p>9-3-6(a)</p> <p>483.460(m)(3) DRUG LABELING Drugs and biologicals packaged in containers designated for a particular client must be immediately removed from the client's current medication supply if discontinued by the physician.</p> <p>Based on observation, record review and interview, the facility failed to establish a system to insure immediate removal of discontinued medications from the current medication supply to prevent medications being given in error for 1 of 4 sampled clients (client #2) after the medications were discontinued by the</p>	W 392	<p>manager will be observing medication passes and reviewing the procedures on the correct passage of medications with staff monthly. Retraining or disciplinary action will be taken for medication errors. The frequency of observations will be revised as necessary.</p> <p>Responsible parties: Residential Manager, Residential Home Staff, Residential Nurse, QIDP</p> <p>W392 The home manager will review with staff the procedures on discontinuation of medications. Client #2's medication packages were sent to the pharmacy along with the order for the discontinued medication. Client #2's medications were repackaged with the correct medications and sent</p>	04/04/2015

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	<p>physician.</p> <p>Findings include:</p> <p>During observations of the morning routine, client #2 came to the facility's office on 3/3/15 at 7:35 AM for medications. Client #2 received 500 mg. (milligrams) of niacin (supplement for cholesterol). Contained in the blister type packaging for the date 3/3/15 at 7:00 AM was a fish oil capsule (supplement for cholesterol). Staff #7 indicated (3/3/15 at 7:35 AM) the fish oil had been discontinued by the client's physician but it still remained with her current medications (3/3-3/14/15).</p> <p>Review of the client's medication packages on 3/3/15 at 9:30 AM indicated pharmacy packaging dated 2/17/15 (when the medications were put into blister type packages) for the March 2015 time period. The 3/15 through 3/31/15 packages still contained the fish oil capsules.</p> <p>Review of client #2's record (3/3/15 at 10:00 AM) indicated client #2's fish oil capsule had been discontinued by the family doctor's nurse practitioner during an appointment on 1/29/15. This was done in response to the client having difficulty swallowing a large soft capsule.</p>		<p>back to the home. The correct medications are now in place and being administered.</p> <p>To protect others and prevent recurrence: Home managers were advised of the procedures for discontinued medications at the team meeting. Home managers will be implementing the procedure for discontinued medications by making sure all medications are removed from the medication packages the date of the order to be discontinued. The home managers will document on the MAR any medication discontinuations on the date ordered for the discontinuation.</p> <p>Quality assurance: When medication audits are being done weekly, staff will check the MAR for any medication discontinuations and alert home manager to any discontinued medications that are in the clients' medication packages.</p> <p>Responsible parties: Residential Manager, Residential Home Staff</p>				

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	<p>Interview with House Manager #3 on 3/3/15 at 9:30 AM indicated client #2 had difficulty swallowing the large fish oil capsule and it was discontinued on 1/29/15. The interview indicated the pharmacy continued to fill the medication and the discontinuation order should be sent to the pharmacy.</p> <p>9-3-6(a)</p>			