

|   |   |   |   |                      |   |
|---|---|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION            |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G468 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____  |                      | X3) DATE SURVEY COMPLETED<br><br>09/06/2012 |
| NAME OF PROVIDER OR SUPPLIER<br><br>BLUE RIVER SERVICES INC |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>5771 E SPEED RD<br>MILLTOWN, IN 47145                                  |                      |   |
| (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>Dates of Survey: September 4, 5, and 6, 2012.</p> <p>Facility number: 000982<br/>Provider number: 15G468<br/>AIM number: 100385530</p> <p>Surveyor: Dotty Walton, Medical Surveyor III.</p> <p>These federal deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review completed 9/14/12 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.

|   |  |   |   |  |  |   |  |
|---|--|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION            |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G468 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                   |  | X3) DATE SURVEY COMPLETED<br><br>09/06/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>BLUE RIVER SERVICES INC |  |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>5771 E SPEED RD<br>MILLTOWN, IN 47145 |  |   |  |
| (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   |  |   |  |
| W0215   | <p>483.440(c)(3)(iv)<br/>INDIVIDUAL PROGRAM PLAN<br/>The comprehensive functional assessment must identify the client's needs for services without regard to the actual availability of the services needed.</p> <p>Based on observation, record review and interview for 1 of 4 sampled clients (#4), the facility failed to ensure the client's comprehensive functional assessment/CFA contained current sleeptime positioning and wheelchair assessments to ensure therapeutic body alignment for client #4.</p> <p>Findings include:</p> <p>Observations were conducted at the facility from 4:15 PM until 6:30 PM on 9/04/12 and on 9/05/12 from 6:00 AM until 8:00 AM. Client #4 required the use of an adapted wheelchair for mobility. The client did not sit upright in the wheelchair, but leaned over at the waist and to his right side. The client transferred to an armchair for the evening meal at 6:00 PM on 9/04/12. The client's upper body and head leaned over and to his right. The client was prompted by staff #4 to hold his head up during the meal as he fed himself with his left hand. On 9/05/12 at 10:00 AM, client #4's bedroom was observed. The client's bed was against a wall with the right/east side of</p> | W0215   | <p>The group home manager made an appointment for a wheel chair assessment for client #4, as well as a physical therapy appointment to client #4's sleeping position. The group home manager will train all staff on any recommendations that were made during these assessments. Additionally, the client's weight was recorded.</p> <p>To protect other clients: All group home clients' functional assessments and adaptive devices are reviewed annually by the QDDP. This will continue so that all client needs are addressed and to ensure that all adaptive devices are in good operational condition.</p> <p>To prevent recurrence: A wheel chair assessment will be conducted annually to ensure it remains in good condition. A physical therapist will be seen in the future if any changes in functioning are observed. Finally, client #4 will have his weight measured bimonthly to ensure he is within the weight limitations for his wheel chair.</p> <p>Responsible party: Group home manager</p> | 10/06/2012   |  |   |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION            |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G468 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____  |                      | X3) DATE SURVEY COMPLETED<br><br>09/06/2012 |
|---|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>BLUE RIVER SERVICES INC |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>5771 E SPEED RD<br>MILLTOWN, IN 47145                                  |                      |   |
| (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>the bed open. The bed had a wedge situated between the mattress and the boxed springs to elevate the client's head during sleeptime. The wedge was more narrow than the springs and mattress so the mattress was higher on the wall side. The tilt of the mattress did not appear conducive to therapeutic sleeptime positioning for client #4.</p> <p>Review of client #4's record on 9/05/12 at 8:04 AM indicated his diagnoses included, but were not limited to, closed head injury (motor vehicle/bicycle wreck at age 13), right side hemiplegia, cerebral palsy and acid reflux. The review indicated client #4 had been assessed for the current wheelchair on 11/18/09 and it had been delivered in June of 2010. Prior to the 11/18/09 appointment, a preliminary evaluation had been conducted on 10/30/09. The evaluation dated 10/30/09 indicated the most recent weight at that time was listed as 120 pounds with a height of 5 feet 4 inches. The record review indicated a dietary assessment dated 1/21/12 which listed his weight as 126.5 pounds and a height of 5 feet 7 inches. The record review indicated no more recent weight measurement. The client. The client's positioning and mobility needs had not been assessed since October/November 2009.</p> |   |   |                      |   |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G468 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>09/06/2012 |
|--|---|--|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>BLUE RIVER SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE<br>5771 E SPEED RD<br>MILLTOWN, IN 47145 |
|---|--|

| (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>Interview with staff #1 on 9/05/12 at 9:30 AM indicated client #4's current weight had not been obtained at the time of the survey. The interview indicated the most recent wheelchair evaluation was the one conducted in October and November of 2009. The interview indicated no evidence of a sleeptime positioning assessment for client #4.</p> <p>9-3-4(a)</p> |               |   |                      |

|   |  |   |   |  |  |   |  |
|---|--|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION            |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G468 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                   |  | X3) DATE SURVEY COMPLETED<br><br>09/06/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>BLUE RIVER SERVICES INC |  |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>5771 E SPEED RD<br>MILLTOWN, IN 47145 |  |   |  |
| (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   |  |   |  |
| W0240   | <p>483.440(c)(6)(i)<br/>INDIVIDUAL PROGRAM PLAN<br/>The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on observation, record review and interview for 1 of 4 sampled clients (#1), the facility failed to ensure the client's program contained methodologies to address his gastric issues.</p> <p>Findings include:</p> <p>During observations on 9/05/12 at 6:23 AM, client #1 received his morning medications from staff #4. Client #1 was administered omeprazole 40 mg/milligrams (for excess gastric acid), and sucralfate 1 gram (forms protective coating on ulcer surface).</p> <p>Review of client #1's record on 9/5/12 at 8:40 AM included the 9/12 medication administration record/MAR which indicated client #1 was prescribed omeprazole 40 mg. at 7:00 AM daily for "stomach." Client #1's 9/12 MAR indicated client #1 was prescribed sucralfate 1 gram daily prior to meals and at hour of sleep at 8:00 PM daily for "stomach." Review of client #1's record indicated no plan with methodologies which included the client's diagnoses, reasons for the medications or instructions for best practice in</p> | W0240   | <p>A doctor's appointment was made for client #1 on September 19 th , 2012 to assess his need for the medications omeprazole and sucralfate and to determine the methodology by which these medications should be taken.</p> <p>To protect others: Our nurse trains all newly hired staff members on the proper administration of medication and on each clients' specific care plans and medications.</p> <p>To prevent recurrence: The doctor discontinued client #1's medication, sucralfate. The doctor recommended no specific time for client #1 to take omeprazole, so it will continue to be taken daily at 7:00 AM. Though the reviewer stated that there was no documentation for the outcomes of medical procedures client #1 underwent (an EGD (esophagogastroduodenoscopy) and a colonoscopy), she was in fact shown this documentation, which states that client #1 was diagnosed with a hiatal hernia. If necessary, that documentation can be presented again. Because of the change in client #1's mediation, the nurse will re-train all staff members on his</p> | 10/06/2012   |  |   |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION            |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G468 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____   |                      | X3) DATE SURVEY COMPLETED<br><br>09/06/2012 |
|---|--|---|--|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>BLUE RIVER SERVICES INC |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>5771 E SPEED RD<br>MILLTOWN, IN 47145                                     |                      |   |
| (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>administering the medications to treat client #1's symptoms. The record review indicated client #1 had two medical procedures on 7/12/12; an EGD/esophagogastroduodenoscopy and a colonoscopy. The record contained no documentation from the consulting physician or the primary care physician regarding the outcome of the procedures 7/12/12, no diagnoses, no information concerning treatment methods and no information concerning future needs.</p> <p>Interview with staff #1 on 9/6/12 at 11:30 AM indicated there was no plan with methodologies for staff to follow in regards to client #1's stomach issues.</p> <p>9-3-4(a)</p> |   | <p>care plans and the administration of his medications.</p> <p>Responsible party: Group home manger and nurse</p> |                      |   |

|   |   |   |  |  |  |   |  |
|---|---|---|--|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION            |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G468 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                   |  | X3) DATE SURVEY COMPLETED<br><br>09/06/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>BLUE RIVER SERVICES INC |   |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>5771 E SPEED RD<br>MILLTOWN, IN 47145 |  |   |  |
| (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)<br/>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 1 of 28 medications observed, for 1 of 4 sampled clients (#1), the facility failed to ensure all prescribed medications were administered according to the physician's orders, without error.</p> <p>Findings include:</p> <p>During observations on 9/05/12 at 6:23 AM, client #1 received his morning medications from staff #4 including sucralfate 1 gram (forms protective coating on ulcer surface). The medication package (reviewed during the medication administration), indicated the sucralfate was to be given before meals and at bedtime.</p> <p>Review of client #1's record on 9/5/12 at 8:40 AM included the 9/12 medication administration record/MAR which indicated client #1 was prescribed sucralfate 1 gram daily prior to breakfast at 7:00 AM.</p> <p>Review of client #1's 7/2/12 physician's order on 9/6/12 at 10:30 AM indicated client #1 was prescribed 1 gram of sucralfate four times daily; prior to meals</p> | W0369   | <p>A doctor's appointment was made for client #1 on September 19 th , 2012 to assess his need for the medications omeprazole and sucralfate and to determine the methodology by which these medications should be taken.</p> <p>To protect others: The group home manager trains all newly hired staff members on the proper administration of medication and on each clients' specific care plans and medications.</p> <p>To prevent recurrence: The doctor discontinued client #1's medication, sucralfate. The doctor recommended no specific time for client #1 to take omeprazole, so it will continue to be taken daily at 7:00 AM. Because of the change in client #1's mediation, the nurse will re-train all staff members on his care plans and the administration of his medications.</p> <p>Responsible party: Group home manger and nurse</p> | 10/06/2012   |  |   |  |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G468 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>09/06/2012 |
|--|---|--|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>BLUE RIVER SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE<br>5771 E SPEED RD<br>MILLTOWN, IN 47145 |
|---|--|

| (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>and at bedtime.</p> <p>Interview with staff #4 on 9/5/12 at 6:30 AM indicated client #1 had breakfast between 5:00 AM and 5:15 AM daily. The interview indicated client #1 had his medications every morning after breakfast.</p> <p>9-3-6(a)</p> |  |  |  |
|--|--|--|--|--|

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION            |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G468 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                   |  | X3) DATE SURVEY COMPLETED<br><br>09/06/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>BLUE RIVER SERVICES INC |  |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>5771 E SPEED RD<br>MILLTOWN, IN 47145 |  |   |  |
| (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   |  |   |  |
| W0436   | <p>483.470(g)(2)<br/>SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review and interview for 1 of 3 sampled clients (#4), who had adaptive equipment, the facility failed to ensure the client's wheelchair was well fitting, maintained and kept in good repair.</p> <p>Findings include:</p> <p>Observations were conducted at the facility from 4:15 PM until 6:30 PM on 9/04/12 and on 9/05/12 from 6:00 AM until 8:00 AM. Client #4 required the use of an adapted wheelchair for mobility. The right wheel of client #4's wheelchair had worn tread. The adapted seating structure of client #4's wheelchair was worn and appeared to have silver colored tape on the right side. When the seating structure was removed, the body/frame of the wheelchair contained debris (food/lint particles).</p> <p>Review of client #4's record on 9/05/12 at 8:04 AM indicated he had been assessed for the current wheelchair in 11/09 and it had been delivered in June of 2010. The</p> | W0436   | <p>The group home manager made an appointment for a wheel chair assessment for client #4 to ensure that the wheel chair is in good operating condition.</p> <p>To protect other clients: All group home clients' functional assessments are reviewed annually by the QDDP. This will continue so that all client needs are addressed and to ensure that all adaptive devices are in good operational condition.</p> <p>To prevent recurrence: A wheel chair assessment will be conducted annually to ensure it remains in good operating condition. A physical therapist will be seen in the future if any changes in functioning level are observed. The group home manager will create a daily cleaning schedule for the wheel chair that staff will sign off on, though client #4 will be frequently urged to keep his wheel chair clean. Finally, client #4 will have his weight measured bimonthly to ensure he is within the weight limitations for his wheel chair.</p> | 10/06/2012   |  |   |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION            |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G468 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____  |                      | X3) DATE SURVEY COMPLETED<br><br>09/06/2012 |
|---|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>BLUE RIVER SERVICES INC |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>5771 E SPEED RD<br>MILLTOWN, IN 47145                                  |                      |   |
| (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>wheelchair had not received repair or modification since that time.</p> <p>Interview with staff #1 on 9/05/12 at 9:30 AM indicated the client's wheelchair was in need of repair.</p> <p>9-3-7(a)</p> |   | Responsible party: Group home manager   |                      |   |