

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G468	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/18/2012
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NAME OF PROVIDER OR SUPPLIER  BLUE RIVER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5771 E SPEED RD MILLTOWN, IN 47145
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(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 a post certification revisit (PCR) to the annual fundamental recertification and state licensure survey completed on September 6, 2012.</p> <p>Dates of Survey: October 16, 17 and 18, 2012.</p> <p>Facility number: 000982 Provider number: 15G468 AIM number: 100385530</p> <p>Surveyor: Dotty Walton, Medical Surveyor III.</p> <p>This federal deficiency reflects state findings in accordance with 460 IAC 9. Quality Review completed 10/22/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		

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

TITLE

(X6) DATE

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

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W0436	<p>483.470(g)(2) 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 owned workshop on 10/16/12 from 10:10 AM until 11:00 AM. Client #4 was sitting in his adapted wheelchair and leaning over to reach into a box of plastic containers on the floor. The right wheel of client #4's wheelchair had worn tread. The adapted seating structure of client #4's wheelchair was worn and he was not seated in a therapeutic manner.</p> <p>During observations at the facility on 10/16/12 at 4:38 PM, client #4 mobilized himself into the facility's office area to receive his medication. The wheelchair did not support his upper body in a therapeutic manner. The wheelchair's right brake was in the "on" position, but</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: The wheel chair was not assessed in time for the revisit survey because an appointment could not be made with the doctor until after the revisit. This will be avoided in the future by contacting other doctors if necessary in order to attain an earlier appointment. Upon assessment, the wheel(s) will be replaced, modifications to the seat molding will be made, and the brakes will be repaired. A wheel chair assessment will be conducted annually to ensure it remains in good operating condition. The group home manager will create a daily</p>	11/17/2012			

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	<p>did not impede his progress into the room. The brake was in need of repair.</p> <p>An assessment dated 10/03/12 by the consulting OT/Occupational Therapist was reviewed on 10/16/12 at 2:30 PM. The OT assessment indicated the client's chair had been assessed as requiring modifications to the seat molding and new hardware fittings. The seat moldings and new hardware fittings had not been completed at the time of the survey.</p> <p>Interview with staff #1 on 10/16/12 at 2:14 PM indicated client #4 had a wheelchair assessment for needed repairs. The repairs required prior authorization and two return trips to the consultants for their completion at a future date.</p> <p>This deficiency was cited on 9/06/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-7(a)</p>		<p>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. Last, a goal will be put in place for client #4 to maintain proper posture while in the wheelchair.</p> <p>Responsible party: Group home manager</p>				