

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/13/2013
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NAME OF PROVIDER OR SUPPLIER BLUE RIVER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 293 SUMMIT VIEW DRIVE CORYDON, IN 47112
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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
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Survey Dates: May 6, 7, 8, 13, 2013</p> <p>Provider Number: 15G503 Aims Number: 100385650 Facility Number: 001017</p> <p>Surveyor: Mark Ficklin, QIDP</p> <p>This deficiency also reflects state findings in accordance with 460 IAC 9. Quality Review completed 5/17/13 by Ruth Shackelford, QIDP.</p>	W000000		
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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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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review, and interview, the facility failed for 1 of 4 sampled clients (#2) to ensure the client #2's dining training program was implemented when opportunities were present.</p> <p>Findings include:</p> <p>An observation at the group home was done on 5/7/13 from 6:32a.m. to 7:50a.m. Client #2 received his medication at 6:32a.m. Client #2 was given a regular style glass of water to take his medication with. Client #2 had shaking hands while holding the regular style cup. Client #2 spilled water while holding the cup and when drinking from the cup. Client #2 had spilled water on his shirt and pants. At 6:47a.m. client #2 ate breakfast. Client #2 used a cup with a lid and a straw. Client #2 also used wrist weights to help steady himself.</p> <p>The record of client #2 was reviewed on 5/7/13 at 1:43p.m. Client #2's 6/20/12</p>	W000249	<p>W249</p> <p>Client #2 is now using his adaptive cup when taking his medications and at all times when eating.</p> <p>To protect other clients and prevent recurrence: The staff at this facility was retrained on client #2's adaptive eating equipment on 5/21/13. Staff will be trained on all adaptive devices for all clients when they are ordered.</p> <p>Quality Assurance: The Residential Manager will observe staff to ensure that they are implementing adaptive devices correctly. The manager will initiate retraining as necessary when adaptive devices are not being used correctly.</p> <p>Responsible parties: Residential Manager, QMRP.</p>	05/31/2013			

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	<p>individual support plan (ISP) indicated client #2 was to use an adaptive non-spill cup and wrist weights during drinking and eating.</p> <p>Interview of staff #1 on 5/7/13 at 2:09p.m. indicated client #2 should use his adaptive cup at all opportunities.</p> <p>9-3-4(a)</p>						