

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G642	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/21/2015
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NAME OF PROVIDER OR SUPPLIER BLUE RIVER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1365 MARVY LN PALMYRA, IN 47164
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W000000	<p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>Dates of Survey: January 20 and 21, 2015.</p> <p>Surveyor: Dotty Walton, QIDP</p> <p>Facility Number: 001109 AIM Number: 100240270 Provider Number: 15G642</p> <p>The following deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review completed 1/29/15 by Ruth Shackelford, QIDP.</p>	W000000		
W000368	<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 3 sampled clients (#2 and #3), and one additional client (client #4), the facility failed to ensure all medications were administered according to the physician's orders without error.</p>	W000368	<p>W368 The nurse retrained staff on all medication procedures. The nurseheld a training meeting and reviewed with staff the policy and procedures on givingall medications correctly and according to the physicians' orders. The</p>	02/20/2015

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>Findings include:</p> <p>Facility incident reports and BDDS (Bureau of Developmental Disabilities Services) reports which included medication error reports were reviewed on 1/21/15 at 1:30 PM. The review indicated the following medications not administered according to the physician's orders:</p> <p>A BDDS report of 1/24/14 indicated on 1/23/14 at 4:30 PM client #4 had not been given his 4:00 PM daily medications (all used to treat chronic constipation) of Miralax 17 grams, Mineral oil 3 teaspoons and lactulose 7 teaspoons.</p> <p>A BDDS report dated 3/8/14 indicated client #4 had not been given his levothyroxine (thyroid hormone) 0.1mg/milligrams at 6:00 AM on 3/8/14.</p> <p>A BDDS report dated 5/1/14 indicated client #2's "partially dissolved" omeprazole (for acid reflux) was found on the floor on 5/1/14 at 7:00 PM. The medication was administered at 4:00 PM.</p> <p>A BDDS report dated 9/30/14 indicated client #3 had been given Azilect 1mg. twice daily (for Parkinsonism/neurologic disorder) on 9/25, 26, 27, 28, and 29/14</p>		<p>nurseobserved each staff member conduct a medication pass to ensure that they werefollowing correct procedures. The manager also reviewed the policy andprocedures on medication incidents and the procedure on how to make sure thatall medications are taken by the clients. Staff was retrained by the nurse onhow to fill out the MAR correctly to ensure proper administration ofmedications. The manager will observestaff daily to ensure compliance with correct medication pass procedures. Thiswill continue until staff demonstrate correct procedures consistently. To protect other clients and prevent reoccurrence: Thepolicy and procedure plans on medication dispensing will be reviewed anddistributed to managers and put into effect by due date. Staff will be checkingclients for any medications that may not have been swallowed. Staff will bechecking the MAR twice during the medication pass and will check the MAR againafter med pass for any medications that may have been overlooked. Newprocedures will be added to address checking the accuracy of the information onthe MAR when they are prepared each month.</p> <p>Quality Assurance: The nurse will observe staff givingmedications to the clients once a month. The manager will be observingmedication passes and reviewing the procedures on the</p>		

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	<p>when it had been first prescribed by the physician to be given only once daily. Staff #2, who made out the error report, indicated she had filled out the MAR incorrectly and the consulting pharmacist had found the errors during the pharmacist's quarterly visit.</p> <p>Review (1/21/15 9:30 AM) of client #2's 1/15 Medication Administration Record/MAR indicated client #4 was to receive one omeprazole 20 mg. capsule at 4:00 PM daily.</p> <p>Review (1/21/15 9:42 AM) of client #4's 1/15 MAR indicated he received levothyroxine 0.1mg. once daily in the morning (6:00 AM) one half hour prior to eating, Miralax 17 grams once daily at 4:00 PM, Mineral oil 3 teaspoons at 4:00 PM and lactulose 7 teaspoons at 4:00 PM.</p> <p>Interview with staff #1 on 1/21/15 at 9:50 AM indicated medications were to be given according to the physician's orders.</p> <p>9-3-6(a)</p>		<p>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 and will include the nurse as deemed necessary.</p> <p>Responsible party: Group Home Manager, Nurse</p>		

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W000369	<p>483.460(k)(2) DRUG ADMINISTRATION 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 3 of 53 medications observed affecting one additional client (client #4), the facility failed to ensure all medications were administered according to the physicians' orders without error.</p> <p>Findings include:</p> <p>Observations of the medication administrations were conducted on 1/20/15 from 3:50 PM until 4:15PM and on 1/21/15 from 6:25 AM until 7:50AM and indicated the following:</p> <p>Client #4 was given his medications by staff #5 at 4:00 PM on 1/20/15. He was given (all used to treat chronic constipation) Miralax 17 grams, Mineral oil 7 teaspoons and lactulose 3 teaspoons. Client #4 was given Miralax 17 grams on 1/21/15 at 7:15 AM by staff #1.</p>	W000369	<p>W369 The nurse met with all staff and did a retraining on the dispensing of medications and on performing the 3 checks of the medication label with the MAR when giving medications to clients. These three steps were reviewed from the medication checklist which is part of the policy and procedures for medication administration. The nurse observed each staff member conduct a medication pass to ensure that they were following correct procedures. The manager will observe staff pass medications daily to ensure compliance with correct medication pass procedures. This will continue until staff demonstrate correct procedures consistently.</p> <p>To Protect Other Clients and Prevent recurrence: The policy and procedure plans on medication administration will be reviewed and given to managers. They will review this</p>	02/20/2015

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W000455	<p>Review (1/21/15 9:42 AM) of client #4's 1/15 MAR indicated he received Miralax 17 grams once daily at 4:00 PM not at 7:00 AM. The dosages of the Mineral oil and lactulose had been reversed at 4:00 PM on 1/20/15 by staff #5; the 1/15 MAR indicated the dosages as Mineral oil 3 teaspoons at 4:00 PM and lactulose 7 teaspoons at 4:00 PM.</p> <p>Interview with staff #1 on 1/21/15 at 9:50 AM indicated medications were to be given according to the physicians' orders.</p> <p>9-3-6(a)</p> <p>483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation and interview for 3 of 3 sampled clients (#1, #2, and #3), and two additional clients (#4 and #5), the facility failed to ensure all clients exhibited handwashing as opportunities</p>	W000455	<p>with staff by the due date. The review policy will include the three checks of comparing the medication labels with the MAR; before opening the medication packaging, during the removal of the medication from the packaging, and before giving the medication to the client.</p> <p>Quality Assurance: The nurse will observe staff giving medications to the clients once a month. The 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 and will include the nurse as deemed necessary.</p> <p>Responsible Party: Group Home Manager, Nurse</p> <p>W455 The manager met and retrained all staff at this facility on proper hand washing hygiene/infection control measures that are to be used by the clients during medication passes. The manager will</p>	02/20/2015			

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	<p>presented.</p> <p>Findings include:</p> <p>Observations were conducted at the facility of clients #1, #2, #3, #4, and #5 on 1/20/15 from 3:00 PM until 5:30PM. Client #4 was observed to be hand mouthing. Client #5 received medications from staff #5 at 3:50 PM, she was not directed to wash or sanitize her hands before medications. Client #4 received medications at 4:00 PM without washing or sanitizing his hands. Client #3 received medications at 4:05 PM with no hand washing. Client #2 received medications at 4:10 PM without being prompted to wash her hands. Client #1 received medications at 4:15 PM without being prompted to wash her hands.</p> <p>Staff #4 was asked (1/20/15 4:15 PM) why clients did not wash their hands prior to the medication administration. Staff #4 indicated clients were prompted to wash hands after toileting but she stated she had "not thought of it" prior to medications.</p> <p>9-3-7(a)</p>		<p>observe all staff to ensure they are prompting clients to wash hands before medication passes. The manager will observe staff pass medications at least three times per week until it is evident that they are consistently prompting clients to wash hands before receiving medications. When that has been accomplished the monitoring will be reduced to at least one time per week. To Protect Other Clients and Prevent recurrence: A revision of the Medication Administration Checklist will now include staff asking all clients to wash their hands before all medication passes. The group home manager will review the checklist with staff. The manager will use the checklist during medication pass observations. The manager will document staff's competency on the procedures during this observation. The revised checklist has been distributed to all managers and has been put into effect immediately. Quality Assurance: Home Managers will observe client's medication passes at least one time a month. If staff do not prompt clients to demonstrate appropriate infection control measures by washing hands before medication passes the Home Manager will initiate additional training for staff or disciplinary action as necessary. Responsible Party: Group Home Manager</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

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