

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  03/02/2016
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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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W 0000  Bldg. 00	<p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>Dates of Survey: February 24, 25, 26 and March 2, 2016.</p> <p>Facility Number: 001109 AIM Number: 100240270 Provider Number: 15G642</p> <p>The following federal deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 3/16/16.</p>	W 0000		
W 0249  Bldg. 00	<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 for 3 of 3 sampled clients (#1, #2 and #3), and two additional clients (#4 and #5) the facility failed to ensure staff</p>	W 0249	W249 Program implementation Corrective Action: The group home manager held a meeting with all staff on March 24 and retrained them on the correct	04/01/2016

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>implemented training during formal and informal opportunities.</p> <p>Findings include:</p> <p>Observations were conducted at the facility on the afternoon of 2/24/16 from 4:00 PM until 6:05 PM. Client #4 came into the facility without staff, opened the refrigerator and drank an opened diet coke. At 4:45 PM, staff #4 started preparing the evening meal. Staff obtained cooking utensils and pans. Staff #4 cooked chicken with dumplings and peas. Staff #4 added seasonings and stirred the food on the stove. Clients #1, #2, #3, #4, and #5 were in the living/dining area but were not involved the meal preparation.</p> <p>Client #4's food was pureed by staff #11. The blender made a loud noise as the food was pureed. Client #4 became visibly agitated and bit his wrist when the blender was operated. Client #5 stated in a loud voice: "Stop it!" Clients came to the dining table and started eating their meals at 5:40 PM on 2/24/16. Staff #4 cut client #3's chicken up while on her plate at the dining table without prompting or doing a hand over hand assist. Client #4 ate his meal at a rapid pace and left the table area. Staff #4 rinsed his plate and utensils and placed them in the dishwasher. Staff #4 washed the pots and</p>		<p>procedure for mealtime protocols with all clients and the guidelines for implementing the dining plans including any choking risks procedures for clients' #1, #2, #3, and #4. To protect other clients all group home managers have been advised to retrain their staff on the correct procedures for implementing the dining plans, choking risks, and procedures for any other mealtime practices of their clients. Training records completed on this matter will be sent to the residential director for review by correction date. To prevent recurrence the group home manager will do scheduled daily observations of the staff during meal times for one month, to ensure that the dining plans and all mealtime protocols are being implemented by the staff. A list of dates and time of the observations will be sent to the residential director. The manager will carry out unannounced visits during mealtimes thereafter. An annual staff meeting given by the home managers will be held to review all dining plans and mealtime protocols of the clients. The IDT team, which will include the facilities' nurse, will review and update all dining plans annually to ensure that they are in compliance with the needs of the clients. All new staff will be trained in orientation on the correct procedures for following the dining plans, choking risks, and the protocol for meal time</p>		

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	<p>pans while clients ate their meal. Clients #1, #2 and #5's place settings were cleared by staff, rinsed and loaded into the dishwasher.</p> <p>During morning observations at the facility on 2/25/16 from 5:45 AM until 8:00 AM the morning meal and its preparation was observed. Staff #5 assisted clients with morning hygiene, dressing and medications. Staff #1 supervised the living/dining/kitchen area. Staff #1 prepared oatmeal for client #4. Client #4 ate in a fast manner and accidentally knocked his bowl onto the floor. Clients #2 and #3's cereal and toast were prepared and served by staff #1 to them at the table. Clients were not involved in the meal preparation process. Staff #1 did not sit at the dining table with the clients. Client #5 ate cereal with milk at 7:45 AM.</p> <p>Review of client #1's dining program (implementation date of 8/19/05) on 2/25/16 at 1:00 PM indicated she was at risk for choking and staff were to stay at the table with her while she ate/drank.</p> <p>Client #2's record was reviewed on 2/25/16 at 10:20 AM. The review indicated a dining plan dated 4/23/15 which indicated the client received fork mashed soft vegetables and ground meats</p>		<p>with the clients. To safeguard that the dining plans are being implemented by the staff, the group home managers will do unannounced visits during mealtimes. These visits will include various days and times to ensure that all staff are carrying out the correct procedures. If any staff are found to be deficient in following the clients' dining plans and mealtime protocols, additional training will be given or disciplinary action may be given to that staff if warranted. Responsible parties will include the group home manager and IDT team.</p>		

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W 0368	<p>to decrease her risk of choking. Staff were to sit at the table with her to supervise.</p> <p>Client #3's record was reviewed on 2/25/16 at 11:30 AM and indicated she was to be supervised at all meals and her foods were to be modified to decrease the risk of choking.</p> <p>Review of client #4's 4/23/15 dining program on 2/25/16 at 1:15 PM indicated he was at risk for choking. Staff were to supervise him at all meals to assure single bites of food and sips of liquids and to decrease his rate of eating.</p> <p>During an interview on 2/24/16 at 4:40 PM, staff #3 stated client #4 "likes [client #1's] cokes." Interview with staff #11 on 2/24/16 at 5:30 PM indicated the blender used to puree client #4's food was old, slow and had to be "pulsed" to properly modify the food.</p> <p>Interview with administrative staff #1 on 2/25/16 at 11:15 AM indicated clients should receive training from staff and be actively involved in the meal preparation.</p> <p>9-3-4(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION</p>				

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Bldg. 00	<p>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 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>Review (2/25/16 9:30 AM) of client #4's 2/16 Medication Administration Record/MAR indicated client #4 was to receive 3 teaspoons of mineral oil at 4:00 PM and 9:00 PM daily. The MAR review indicated staff had documented on 2/13/16 client #4 had missed both doses and had missed one dose on 2/14/16 because there was no mineral oil available in the facility for client #4.</p> <p>Interview with administrative staff #1 on 2/25/16 at 11:00 AM indicated medications were to be given according to the physician's orders.</p> <p>9-3-6(a)</p>	W 0368	<p>W368 DrugAdministration Corrective Action: Staff were retrained at the staff meeting, on the correct medication procedures for the ordering of all clients' medications. To Protect Other Clients: The group home managers will review the correct procedures on ordering medications with all staff and training records will be sent to the residential director. To Prevent Recurrence: A nightly med audit will be done by staff and a list of any meds requiring to be reordered will be made. The list of meds will be left for the manager to review and ordered the following day. Quality assurance: The staff, upon doing the med audit, will sign off on a checklist. The checklist will be reviewed weekly by the manager. Responsible parties: Home manager and group home staff.</p>	04/01/2016

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W 0460 Bldg. 00	<p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, record review and interview for 2 of 3 sampled clients (#2 and #3), and two additional clients (#4 and #5) the facility failed to ensure staff served the clients the whole menued diet.</p> <p>Findings include:</p> <p>During morning observations at the facility on 2/25/16 from 5:45 AM until 8:00 AM the morning meal and its preparation was observed. Staff #5 assisted clients with morning hygiene, dressing and medications. Staff #1 supervised the living/dining/kitchen area. Staff #1 prepared oatmeal for client #4. Client #4 ate in a fast manner and accidentally knocked his bowl onto the floor. He was not offered fruit juice. Clients #2 and #3's cereal and toast were prepared and served by staff #1 to them at the table. Clients were not involved in the meal preparation process. Staff #1 did not sit at the dining table with the clients.</p>	W 0460	<p>W460 Food and Nutrition Services The manager retrained all staff on the proper protocol for following the daily menu and offering choices to the clients. The manager will make observations during at least one mealtime every day for 30 days and then 4 times a month, thereafter, to ensure that staff offer choices of foods and beverages to the clients. To protect other clients: the managers will retrain all staff on offering choices of other food and beverage items, to the clients' outside of what is on the menu. Training records will be sent to the residential director for review. To prevent recurrence: Staff will be retrained annually on the proper meal protocol and offering choices different from the menus. Four times a month observations will be made by the manager, to ensure that staff are giving alternative food and beverage selections to the clients. Quality assurance: During the managers mealtime</p>	04/01/2016

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W 0488 Bldg. 00	<p>Client #5 ate cereal with milk at 7:45 AM. Client #5 was not offered fruit juice or a substitute.</p> <p>Review (2/25/16 at 10:00 AM) of the facility's menu for the breakfast meal on 2/25/16 indicated clients were to be offered 1/2 cup of grape juice along with hot or cold cereal, toast and milk. During an interview on 2/25/16 at 10:30 AM, staff #1 indicated the clients did not like grape juice so it was not offered. The interview indicated a substitute for the fruit juice the clients would enjoy could have been offered such as fresh fruit.</p> <p>9-3-8(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE</p> <p>The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>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 clients were involved in meal preparation.</p> <p>Findings include:</p> <p>Observations were conducted at the facility on the afternoon of 2/24/16 from 4:00 PM until 6:05 PM. Client #4 came into the facility without staff, opened the</p>	W 0488	<p>observations, if any staff are found to be deficient in offering the clients substitutions on the menus, additional training will be given or disciplinary action may be given to that staff if warranted. Responsible parties: Home manager and group home staff.</p> <p>W488 Dining Areas and Service Corrective Action: The group home manager held a meeting with all staff on instruction and guidance with clients in a manner that is consistent with their developmental level. This training with staff included the correct procedures for training and direction with clients in the preparation and serving of meals. To protect other clients all group home managers have been directed to retrain their staff on</p>	04/01/2016

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	<p>refrigerator and drank an opened diet coke. At 4:45 PM, staff #4 started preparing the evening meal. Staff obtained cooking utensils and pans. Staff #4 cooked chicken with dumplings and peas. Staff #4 added seasonings and stirred the food on the stove. Clients #1, #2, #3, #4, and #5 were in the living/dining area but were not involved the meal preparation.</p> <p>Client #4's food was pureed by staff #11. The blender made a loud noise as the food was pureed. Client #4 became visibly agitated and bit his wrist when the blender was operated. Client #5 stated in a loud voice: "Stop it!" Clients came to the dining table and started eating their meals at 5:40 PM on 2/24/16. Staff #4 cut client #3's chicken up while on her plate at the dining table without prompting or doing a hand over hand assist. Client #4 ate his meal at a rapid pace and left the table area. Staff #4 rinsed his plate and utensils and placed them in the dishwasher. Staff #4 washed the pots and pans while clients ate their meal. Clients #1, #2 and #5's place settings were cleared by staff, rinsed and loaded into the dishwasher.</p> <p>During morning observations at the facility on 2/25/16 from 5:45 AM until 8:00 AM the morning meal and its preparation was observed. Staff #5</p>		<p>the correct procedure of training and guidance with clients while doing meal preparation and the serving of meals. Training records on this material will be sent to the residential director for review by correction date. To prevent recurrence the group home managers will do an annual training with staff to cover the correct procedures on including instruction with the clients' during the meal preparations and the serving of the meals based on their developmental levels. All new staff will be trained in orientation on the correct procedures for instruction and guidance of the clients during meals. To ensure that the staff are carrying out the procedures to include training with the clients' during meals, the group home managers will do four unannounced visits and observations during mealtimes, every month. These observations will include various days and times to ensure that all staff are carrying out the correct procedures of having clients actively involved in mealtime preparation and the serving of meals, based on their developmental abilities. If any staff are not including the instruction with clients in mealtime procedures, additional training will be given to that staff. Responsible party will include the group home manager.</p>	

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	<p>assisted clients with morning hygiene, dressing and medications. Staff #1 supervised the living/dining/kitchen area. Staff #1 prepared oatmeal for client #4. Client #4 ate in a fast manner and accidentally knocked his bowl onto the floor. Clients #2 and #3's cereal and toast were prepared and served by staff #1 to them at the table. Clients were not involved in the meal preparation process. Staff #1 did not sit at the dining table with the clients. Client #5 ate cereal with milk at 7:45 AM.</p> <p>During an interview on 2/24/16 at 4:40 PM, staff #3 stated client #4 "likes [client #1's] cokes." Interview with staff #11 on 2/24/16 at 5:30 PM indicated the blender used to puree client #4's food was old, slow and had to be "pulsed" to properly modify the food.</p> <p>Interview with administrative staff #1 on 2/25/16 at 11:15 AM indicated clients should be involved in the family style meal and its preparation according to their individual capabilities.</p> <p>9-3-8(a)</p>			