

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G302	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/17/2012
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NAME OF PROVIDER OR SUPPLIER MCSHERR INC - BACKMEYER	STREET ADDRESS, CITY, STATE, ZIP CODE 3101 BACKMEYER RD RICHMOND, IN 47374
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W0000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: 10/10/12, 10/11/12 and 10/17/12.</p> <p>Facility Number: 000821 Provider Number: 15G302 AIMS Number: 100243750</p> <p>Surveyor: Keith Briner, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Reivew was completed on 10/19/12 by Tim Shebel, Medical Surveyor III.</p>	W0000	I am attempting to resend the POC that I sent on 11-01-2012.	

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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W0112	<p>483.410(c)(2) CLIENT RECORDS</p> <p>The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records.</p> <p>Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) plus 4 additional clients (#5, #6, #7 and #8), the facility failed to ensure the confidentiality of the clients' medical information.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 10/11/12 from 6:00 AM through 8:00 AM. At 7:07 AM staff #1 began the morning medication administration session. Staff #1 dispensed clients #1, #2, #3, #4, #5, #6, #7 and #8's medications from their individual (PPME) Pharmacy Packaged Medication Envelope. At 7:51 AM staff #1 finished administering clients #1, #2, #3, #4, #5, #6, #7 and #8's medications then placed each of their PPME's in the group home's kitchen trash receptacle. Staff #1 did not shred or redact the clients' PPME prior to placing them in the trash receptacle.</p> <p>Client #1's 10/11/12, 7:00 AM PPME was reviewed on 10/11/12 at 7:17 AM. Client #1's PPME indicated the following information:</p> <p>-client #1's first and last name</p> <p>-the date of the administration</p>	W0112	<p>On 10/11/12 Staff was instructed in the staff communication log that they were to immediately begin using a black marker to obliterate the client's name from the medication packet prior to disposing of the packet (Exhibit A). A black marker is kept in the medication closet as well as in a drawer in the kitchen that can be used for this purpose. They were reminded of his policy at an inservice which they could chose to attend on either 10/29/12 or 11/1/12 (Exhibit B 1-13). The home management team will randomly check the disposed of medication envelopes to ensure that names have been blacked out. In the future, all names will be obliterated pror to disposing of medication envelopes.</p>	11/01/2012			

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	<p>-the time of the dose</p> <p>-the following medications and dose: calcium with vitamin D 500 milligram (supplement), divalproex 500 milligram tablet (seizures), triamterene hydrochlorothiazide 37.5 milligram tablet (blood pressure) and certagen 5 milligram tablet (supplement).</p> <p>Client #2's 10/11/12, 7:00 AM PPME was reviewed on 10/11/12 at 7:07 AM. Client #2's PPME indicated the following information:</p> <p>-client #2's first and last name</p> <p>-the date of the administration</p> <p>-the time of the dose</p> <p>-the following medications and dose: sprintec 28 tablet (birth control), cetirizine 10 milligram tablet (allergies), hydrochlorothiazide 25 milligram tablet (blood pressure) and lisinopril 40 milligram tablet (blood pressure).</p> <p>Client #3's 10/11/12, 7:00 AM PPME was reviewed on 10/11/12 at 7:10 AM. Client #3's PPME indicated the following information:</p> <p>-client #3's first and last name</p> <p>-the date of the administration</p> <p>-the time of the dose</p> <p>-the following medications and dose: loestrin</p>				

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	<p>24 Fe tablet (birth control), bupropion extended release 150 milligram tablet (depression) and loratadine 10 milligram tablet (allergies).</p> <p>Client #4's 10/11/12, 7:00 AM PPME was reviewed on 10/11/12 at 7:22 AM. Client #4's PPME indicated the following information:</p> <ul style="list-style-type: none"> -client #4's first and last name -the date of the administration -the time of the dose -the following medications and dose: banzel 400 milligram tablet (seizures), cetirizine 10 milligram tablet (allergies) and lamotrigine 20 milligram tablet (seizures). <p>Client #5's 10/11/12, 7:00 AM PPME was reviewed on 10/11/12 at 7:30 AM. Client #5's PPME indicated the following information:</p> <ul style="list-style-type: none"> -client #5's first and last name -the date of the administration -the time of the dose -the following medications and dose: bupropion extended release 150 milligram tablet (depression), clomipramine 25 milligram tablet (obsessive compulsive disorder), clomipramine 50 milligram tablet, and enalapril 5 milligram tablet (blood pressure). 				

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	<p>Client #6's 10/11/12, 7:00 AM PPME was reviewed on 10/11/12 at 7:44 AM. Client #6's PPME indicated the following information:</p> <ul style="list-style-type: none"> -client #6's first and last name -the date of the administration -the time of the dose -the following medications and dose: simethicone tablet (ant-acid), levothyroxine 112 milligram tablet(hypothyroidism), lamotrigine 100 milligram tablet (seizures), loratadine 10 milligram tablet (allergies), multivitamin tablet (supplement), omeprazole 200 milligram tablet (gerd), sertraline 500 milligram tablet (depression) and sodium bicarbonate 650 milligram tablet (ant-acid). <p>Client #7's 10/11/12, 7:00 AM PPME was reviewed on 10/11/12 at 7:35 AM. Client #7's PPME indicated the following information:</p> <ul style="list-style-type: none"> -client #7's first and last name -the date of the administration -the time of the dose -the following medications and dose: loestrin 24 Fe tablet (birth control), fluoxetine 40 milligram tablet (depression), lisinopril 5 milligram tablet (blood pressure), risperidol 1 milligram tablet (schizophrenia), and topiramate 100 milligram tablet (seizures). 			

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	<p>Client #8's 10/11/12, 7:00 AM PPME was reviewed on 10/11/12 at 7:51 AM. Client #8's PPME indicated the following information:</p> <ul style="list-style-type: none"> -client #8's first and last name -the date of the administration -the time of the dose -the following medications and dose: calcium 500 milligram tablet (supplement), loratadine 10 milligram tablet (allergies), multivitam tablet (supplement), phenobarbital 250 milligram tablet (seizures) and primidone 250 milligram tablet (seizures). <p>Staff #1 and HM (Home Manager) #1 were interviewed on 10/11/12 at 7:57 AM. Staff #1 and HM #1 indicated the clients' PPME were discarded in the trash after completion of the administration. Staff #1 and HM #1 indicated she had not dedacted the clients' information prior to discarding the PPME's.</p> <p>Interview with AS (Administrative Staff) #2 on 10/11/12 at 10:45 AM indicated staff should be using a permanent marker to dedact each clients PPME before discarding the PPME into the trash. AS #2 indicated the clients PPME contained confidential information.</p> <p>9-1-3(a)</p>						

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W0153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 1 of 9 allegations of abuse, mistreatment or neglect reviewed, the facility failed to immediately notify BDDS (Bureau of Developmental Disabilities Services) regarding the use of a physical restraint for client #1.</p> <p>Findings include:</p> <p>The facility's BDDS reports and investigations were reviewed on 10/10/12 at 1:19 PM. The review indicated the following:</p> <p>-BDDS report dated 8/19/12 indicated on 8/17/12, "The residents had just left the day programming site when staff realized [client #1]'s seatbelt was loose. When they attempted to tighten her seat belt [client #1] became agitated. [Client #1] started trying to bite staff. [Client #1] then grabbed staff's eyeglasses as well as [client #2]'s glasses. Staff held [client #1]'s wrists for 10 seconds, then [client #1] grabbed [client #2]'s glasses again, as well as, staff's. Staff attempted to hold her wrists again, which lasted 10 seconds. The van pulled over and a different staff changed places with the first staff to see</p>	W0153	<p>Staff was reminded at an inservice on 10/29/12 or 11/1/12 (Exhibit B 1&2) that they are to immediately call the home manager or assistant when there is an accident and injury report, an unknown report, or when a restraint has been used to control a client for any purpose. The home managers/assisstant will call he McSherr Social Worker and the Residential Director. The Social Worker is to submit the report to BDDS within 24 hours. Within that 24 hours the Residential Director will contact the Social Worker to inquire if the report has been submitted. If the report has not been submitted, the Social Worker will be instructed to submit it immediately. If the Social Worker is not available or for some reason unable to submit the report, the Residential Director will submit the report. In the future, the Residential Director will continue to contact the Social Worker within 24 hours of receiving notice of a reportable incident from any member of the home management team. Internet has been installed in the home and the Social Worker is to</p>	11/16/2012			

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	<p>if that would help [client #1] calm. The second staff had to hold [client #1]'s wrists for about a minute, then [client #1] calmed the rest of the way."</p> <p>Interview with AS (Administrative Staff) #2 on 10/11/12 at 10:45 AM indicated BDDS reportable incidents included the use of physical restraints. AS #2 indicated BDDS reportable incidents should be reported to BDDS within 24 hours of the incident.</p> <p>9-3-1(b)(5) 9-3-2(a)</p>		<p>train the home manager in the process of reporting so that more individuals are available to submit reports.</p>		

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W0189	<p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) plus 4 additional clients (#5, #6, #7 and #8), the facility failed to ensure staff were trained protect the confidentiality of the clients' medical information.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 10/11/12 from 6:00 AM through 8:00 AM. At 7:07 AM staff #1 began the morning medication administration session. Staff #1 dispensed clients #1, #2, #3, #4, #5, #6, #7 and #8's medications from their individual (PPME) Pharmacy Packaged Medication Envelope. At 7:51 AM staff #1 finished administering clients #1, #2, #3, #4, #5, #6, #7 and #8's medications then placed each of their PPME's in the group home's kitchen trash receptacle. Staff #1 did not shred or redact the clients' PPME prior to placing them in the trash receptacle.</p> <p>Client #1's 10/11/12, 7:00 AM PPME was reviewed on 10/11/12 at 7:17 AM. Client #1's PPME indicated the following information:</p> <p>-client #1's first and last name</p> <p>-the date of the administration</p>	W0189	On 10/12/2012, via the staff communication log, staff were instructed that they must use a black marker to obliterate the client's name from the pharmacy packaged medication envelope after administering the medication but prior to disposing of the envelope (Exhibit A). On 10/29/2012 and 11/1/2012, inservices were held at which time staff were again instructed to black out the client's name on the envelope after administering medications. In the future a black marker will be kept in the medication closet and a kitchen drawer to remind staff that they are to obliterate the client name prior to disposing of the envelope. The home management team will randomly check the medication envelopes that have been disposed of to insure names are blacked out.	11/01/2012			

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	<p>-the time of the dose</p> <p>-the following medications and dose: calcium with vitamin D 500 milligram (supplement), divalproex 500 milligram tablet (seizures), triamterene hydrochlorothiazide 37.5 milligram tablet (blood pressure) and certagen 5 milligram tablet (supplement).</p> <p>Client #2's 10/11/12, 7:00 AM PPME was reviewed on 10/11/12 at 7:07 AM. Client #2's PPME indicated the following information:</p> <p>-client #2's first and last name</p> <p>-the date of the administration</p> <p>-the time of the dose</p> <p>-the following medications and dose: sprintec 28 tablet (birth control), cetirizine 10 milligram tablet (allergies), hydrochlorothiazide 25 milligram tablet (blood pressure) and lisinopril 40 milligram tablet (blood pressure).</p> <p>Client #3's 10/11/12, 7:00 AM PPME was reviewed on 10/11/12 at 7:10 AM. Client #3's PPME indicated the following information:</p> <p>-client #3's first and last name</p> <p>-the date of the administration</p> <p>-the time of the dose</p>				

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	<p>-the following medications and dose: loestrin 24 Fe tablet (birth control), bupropion extended release 150 milligram tablet (depression) and loratadine 10 milligram tablet (allergies).</p> <p>Client #4's 10/11/12, 7:00 AM PPME was reviewed on 10/11/12 at 7:22 AM. Client #4's PPME indicated the following information:</p> <p>-client #4's first and last name</p> <p>-the date of the administration</p> <p>-the time of the dose</p> <p>-the following medications and dose: banzel 400 milligram tablet (seizures), cetirizine 10 milligram tablet (allergies) and lamotrigine 20 milligram tablet (seizures).</p> <p>Client #5's 10/11/12, 7:00 AM PPME was reviewed on 10/11/12 at 7:30 AM. Client #5's PPME indicated the following information:</p> <p>-client #5's first and last name</p> <p>-the date of the administration</p> <p>-the time of the dose</p> <p>-the following medications and dose: bupropion extended release 150 milligram tablet (depression), clomipramine 25 milligram tablet (obsessive compulsive disorder), clomipramine 50 milligram tablet, and enalapril 5 milligram tablet (blood</p>			

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	<p>pressure).</p> <p>Client #6's 10/11/12, 7:00 AM PPME was reviewed on 10/11/12 at 7:44 AM. Client #6's PPME indicated the following information:</p> <ul style="list-style-type: none"> -client #6's first and last name -the date of the administration -the time of the dose -the following medications and dose: simethicone tablet (ant-acid), levothyroxine 112 milligram tablet(hypothyroidism), lamotrigine 100 milligram tablet (seizures), loratadine 10 milligram tablet (allergies), multivitamin tablet (supplement), omeprazole 200 milligram tablet (gerd), sertraline 500 milligram tablet (depression) and sodium bicarbonate 650 milligram tablet (ant-acid). <p>Client #7's 10/11/12, 7:00 AM PPME was reviewed on 10/11/12 at 7:35 AM. Client #7's PPME indicated the following information:</p> <ul style="list-style-type: none"> -client #7's first and last name -the date of the administration -the time of the dose -the following medications and dose: loestrin 24 Fe tablet (birth control), fluoxetine 40 milligram tablet (depression), lisinopril 5 milligram tablet (blood pressure), risperidol 1 milligram tablet (schizophrenia), and 			

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	<p>topiramate 100 milligram tablet (seizures). Client #8's 10/11/12, 7:00 AM PPME was reviewed on 10/11/12 at 7:51 AM. Client #8's PPME indicated the following information:</p> <ul style="list-style-type: none"> -client #8's first and last name -the date of the administration -the time of the dose -the following medications and dose: calcium 500 milligram tablet (supplement), loratadine 10 milligram tablet (allergies), multivitam tablet (supplement), phenobarbital 250 milligram tablet (seizures) and primidone 250 milligram tablet (seizures). <p>Staff #1 and HM (Home Manager) #1 were interviewed on 10/11/12 at 7:57 AM. Staff #1 and HM #1 indicated the clients' PPME were discarded in the trash after completion of the administration. Staff #1 and HM #1 indicated she had not dedacted the clients' information prior to discarding the PPME's. Staff #1 indicated she had been trained to discard the PPME's after completing the medication administration. When asked if she had been trained to use a marker to cover the clients information, staff #1 indicated she had not.</p> <p>Interview with AS (Administrative Staff) #2 on 10/11/12 at 10:45 AM indicated staff should be using a permanent marker to dedact each clients PPME before discarding the PPME into the trash. AS #2 indicated the policy was to use a permanent marker to conceal the clients information.</p> <p>9-3-3(a)</p>						

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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			
W0382	<p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration.</p> <p>Based on observation and interview, the facility failed to assure 8 of 8 clients (client's #1, #2, #3, #4, #5, #6, 7, and #8) medications were maintained in a secure location during the medication administration process.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 10/10/12 from 3:54 PM through 6:15 PM. At 5:10 PM staff #2 exited the medication administration area/kitchen area. Staff #2 left the keys in the door to the medication closet where clients #1, #2, #3, #4, #5, #6, #7 and #8's medications were stored. At 5:15 PM client #7 entered the medication administration/kitchen area with no staff present.</p> <p>Observations were conducted at the group home on 10/11/12 from 6:00 AM through 8:00 AM. At 6:10 AM the medication administration key was in the medication closet where clients #1, #2, #3, #4, #5, #6, #7 and #8's medications were stored. At 6:34 AM staff #1 prompted client #7 to the medication administration/kitchen area where the keys to the medication closet were in the medication administration closets lock. The medication cabinet had keys in the door from 6:10 AM through 6:34 AM with no staff or clients engaged in medication administration activities.</p> <p>Interview with staff #1 on 10/11/12 at 7:57 AM indicated the medication closet door key should not be in the door unattended and while not in use.</p>	W0382	<p>On 10/12/2012, a notice was left in the staff communication log instructing staff that the medication closet must remain locked and the key secured when there is no staff in the area (Exhibit C). On 10/29/12 & 11/1/12 inservices were conducted which emphasized the need to keep the medication closet locked with the key secured elsewhere. All staff did sign a receipt of acknowledgement (Exhibit D 1-11). In the future, all professional staff members will go to the home to randomly check the medication closet to insure that it is locked and the key secured elsewhere. If the key is found in the lock or the closet is found unlocked with no staff in the immediate area, the staff responsible for leaving the closet unlocked or leaving the key in the door with no staff member in the immediate area will be counseled and documented in their file as a verbal warning. If this happens a second time, McSherr disciplinary procedure will be followed. McSherr disciplinary procedure does state "any additional infractions will result in further disciplinary procedure up to, and possibly including, discharge.</p>	11/01/2012			

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	<p>Interview with AS (Administrative Staff) #2 on 10/11/12 at 10:45 AM indicated staff should not leave the medication closet key in the door while not administering medications.</p> <p>9-3-6(a)</p>			

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W9999	<p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met.</p> <p>460 IAC 9-3-1 Governing Body (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by division.</p> <p>This rule was not met as evidenced by:</p> <p>Based on record review and interview for 1 of 9 allegations of abuse, mistreatment or neglect reviewed, the facility failed to immediately notify BDDS (Bureau of Developmental Disabilities Services) regarding the use of a physical restraint for client #1.</p> <p>Findings include:</p> <p>The facility's BDDS reports and investigations were reviewed on 10/10/12 at 1:19 PM. The review indicated the following:</p> <p>-BDDS report dated 8/19/12 indicated on 8/17/12, "The residents had just left the day programming site when staff realized [client #1]'s seatbelt was loose. When they attempted to tighten her seat belt [client #1]</p>	W9999	<p>On 10/29/2012 internet wervice was installed at the group home. The McShesrr Social Worker will teach the home managers how to complete the BDDS reports. A samp;e report wil bes completed (but not submittesd) to familiarize the manager with the procedure. In the future, he manager and he residdentiaol director will be available to submit the requires reports to BDDS in additon to the soscial worker. With multiple individuals available to submit reports, there will be no late reporting.</p>	11/16/2012			

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	<p>became agitated. [Client #1] started trying to bit staff. [Client #1] then grabbed staff's eyeglasses as well as [client #2]'s glasses. Staff held [client #1]'s wrists for 10 seconds, then [client #1] grabbed [client #2]'s glasses again, as well as, staff's. Staff attempted to hold her wrists again, which lasted 10 seconds. The van pulled over and a different staff changed places with the first staff to see if that would help [client #1] calm. The second staff had to hold [client #1]'s wrists for about a minute, then [client #1] calmed the rest of the way."</p> <p>Interview with AS (Administrative Staff) #2 on 10/11/12 at 10:45 AM indicated BDDS reportable incidents included the use of physical restraints. AS #2 indicated BDDS reportable incidents should be reported to BDDS within 24 hours of the incident.</p> <p>9-3-1(b)</p>			