

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G457	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2015
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NAME OF PROVIDER OR SUPPLIER  MCSHERR INC - B ST	STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374
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W 0000  Bldg. 00	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: November 4, 5, 6, 9, 10, 12, 13 and 20, 2015.</p> <p>Facility Number: 000971 Provider Number: 15G457 AIMS Number: 100244800</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 12/2/15.</p>	W 0000		
W 0104  Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview and record review for 4 of 4 sampled clients (#1, #2, #3 and #4) and 4 additional clients (#5, #6, #7 and #8), the governing body failed to exercise general policy, budget, and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent the abuse/neglect of clients #1, #2, #4, #5, #6, #7 and #8, to ensure all allegations of</p>	W 0104	<p><b>Name and Address of Provider:</b> McSherr, Inc., 4412 So. B. Street, Richmond, IN <b>Date Survey Completed:</b> 12/3/15 <b>Provider Identification Number:</b> 15G457 <b>Survey Event ID:</b> DYHD11 <b>Finding: W104-</b> The facility failed to exercise general policy, budget, and operating direction over the facility to ensure:</p>	12/20/2015

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>abuse/neglect were reported immediately to the administrator and to the BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law and an investigation was conducted for clients #1, #2, #4, #5, #6, #7 and #8.</p> <p>The governing body failed to exercise general policy, budget, and operating direction over the facility to ensure sufficient staff was provided at the Day Program (DP) to ensure continual training opportunities and/or choices of leisure activities for client #3, to ensure client #2 was provided a representative to assist in making informed decisions in regard to his medical and psychological needs, to ensure client #7's rights in regard to privacy and dignity while in the restroom and to ensure a full and complete accounting of client #2's personal finances.</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure sufficient staff was provided at the Day Program (DP) to ensure continual training opportunities and/or choices of leisure activities for client #3. Please see</p>		<p>1. sufficient staff was provided at the Day Program to ensure continual training opportunities and/or choices of leisure activities for client #3,</p> <p>2. to ensure client #2 was provided a representative to assist in making informed decisions in regard to his medical and psychological needs, to ensure</p> <p>3. client #7's rights in regard to privacy and dignity while in the restroom and</p> <p>4. to ensure a full and complete accounting of client #2's personal finances.</p> <p><b>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice?</b></p> <p>·1) Day Program Staff were retrained by Day Program Supervisor on 11/23/15 to ensure client #3 has continual training opportunities and/or choices of leisure activities</p> <p>·2) McSherr delivered paperwork completed by PCP to Achieva Resources on 12/9/15 to apply for guardianship for client #2 to ensure client #2 is provided a representative to assist in making informed decisions.</p> <p>·3) Staff that violated client #7's rights in regard to privacy and dignity while in the restroom was terminated from employment with McSherr. Staff at South B Street were retrained on suspected Abuse, Neglect and Exploitation</p>				

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	<p>W120.</p> <p>2. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure client #2 was provided a representative to assist in making informed decisions in regard to his medical and psychological needs. Please see W125.</p> <p>3. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure client #7's rights in regard to privacy and dignity while in the restroom. Please see W130.</p> <p>4. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure a full and complete accounting of client #2's personal finances. Please see W140.</p> <p>5. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent the abuse/neglect of clients #1, #2, #4, #5, #6, #7 and #8, to ensure all allegations of abuse/neglect were reported immediately to the administrator and to the BDDS and APS according to state law for clients #1, #2, #4, #5, #6, #7 and #8.</p>		<p>on 11/23/15 and received an Accelwritten reminder re: respecting Resident Rights and Ensuring Dignity on12/10/15. Staff are required to read thereminder before being granted access to their time cards.</p> <p>·4) House Manager will ensure that client/staff sign/initial receipts whenspending money is given to client #2</p> <p><b>Howwill you identify other residents having the potential to be affected by thesame deficient practice and what corrective action will be taken?</b></p> <p>All consumers have the potential to beaffected for all four findings.</p> <p>·1) McSherr will ensure that all McSherr clientsin the ADA area of the Day Program have sufficient staff for continual trainingopportunities and/or choices of leisure activities through Day ProgramObservation visits. This area of concernwill be added to observation checklist. QIDP will stay in contact with Day Program supervisor to ensurecompliance.</p> <p>·2) McSherr will review need for guardianship for all McSherr clients atProfessional Quarterly Review meetings</p> <p>·3) All staff working in McSherr Group Homes have been retrained onSuspected Abuse, Neglect, and Exploitation at bi-monthly house meetings and</p>				

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	<p>Please see W149.</p> <p>6. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure all allegations of abuse/neglect were reported immediately to the administrator and to the BDDS and APS according to state law for clients #1, #2, #4, #5, #6, #7 and #8. Please see W153.</p> <p>7. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure all allegations of abuse/neglect were investigated for clients #1, #2, #4, #5, #6, #7 and #8. Please see W154.</p> <p>9-3-1(a)</p>		<p>allgroup home staff received a written reminder to respect resident rights andensure dignity through Accel messaging (electronic record keeping systemutilized by McSherr).</p> <p>·4) All group home managers (the only staff with access to client funds)have been instructed to get client/staff signatures/initials on all receiptsfor cash given to clients for spending money.</p> <p><b>Whatmeasures will be put into place or what systemic changes you will make toensure that the deficient practice does not recur?)</b></p> <p>·1) IDT will discuss/review Day Program concernsat monthly IDT and respond accordingly. Professional Quarterly Review will follow up on concerns and responsesfrom IDT</p> <p>·2) McSherr will review need for guardianship for all McSherr clients atProfessional Quarterly Review meetings</p> <p>·3) All staff working in McSherr Group Homes have been retrained onSuspected Abuse, Neglect, and Exploitation at bi-monthly house meetings and allgroup home staff received a written reminder to respect resident rights andensure dignity through Accel messaging (electronic record keeping systemutilized by McSherr).</p> <p>·4) All group home managers (the only staff with access to client funds)have been instructed</p>		

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			<p>to get client/staff signatures/initials on all receiptsfor cash given to clients for spending money.</p> <p><b>Howwill the corrective action(s) be monitored to ensure the deficient practicewill not recur (quality assurance program, etc.) and how will it be put intoplace?</b></p> <ul style="list-style-type: none"> <li>·1) Residential Administrator, QIDP, SSC, and HSC will monitor through review of DayProgram Observation Logs at Monthly IDT and Professional Quarterly Review</li> <li>·2) Social Services Coordinator, QIDP, RA and RN willmonitor through discussion at Monthly IDT</li> <li>·3) SSC will monitor by including questionsrelated to Resident Rights on Quarterly Interview of clients and staff at eachgroup home. RA, QIDP, RN, and SSC willdiscuss concerns related to interviews of staff and clients. Bi-monthly house meetings will includediscussion and training on Resident Rights and Ensuring Dignity.</li> <li>·4) Residential Administrator (RA) will monitorwhen completing monthly finance audits for each client.</li> </ul> <p><b>What is the date by which the systemic changes will be completed? 12/20/15</b></p> <p><b>RespectfullySubmitted, RosemaryTaylor, Residential Administrator</b></p>	

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W 0120 Bldg. 00	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. Based on observation and interview for 1 of 4 sample clients attending outside services (#3), the facility failed to ensure sufficient staff was provided at the Day Program (DP) to provide continual training opportunities and/or choices of leisure activities for client #3.</p> <p>Findings include:</p> <p>Observations were conducted at the day program on 11/13/15 between 1 PM and 2:30 PM.</p> <p>__ There were three rows of large rectangular tables in one large room. One staff was at each row of tables and 20 clients were in the room.</p> <p>__ During this observation period client #3 sat in a chair along the wall of room.</p> <p>__ Client #3 was not involved in any activities and/or training throughout this observation period.</p> <p>__ During this observation period the staff did not sit with or interact with client #3.</p> <p>__ During this observation period the staff did not offer training and/or leisure activities to client #3.</p> <p>During interview with DP staff #2 on</p>	W 0120	<p><b>Name and Address of Provider:</b> McSherr, Inc., 4412 So. B. Street, Richmond, IN</p> <p><b>Date Survey Completed:</b> 12/3/15</p> <p><b>Provider Identification Number:</b> 15G457</p> <p><b>Survey Event ID:</b> DYHD11</p> <p><b>Finding: W120-</b> The facility failed to ensure sufficient staff was provided at the Day Program to provide continual training opportunities and/or choices of leisure activities for client #3</p> <p><b>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>· Day Program Staff were retrained by Day Program Supervisor to ensure client #3 has continual training opportunities and/or choices of leisure activities.</li> <li>· McSherr will ensure that all South B clients in the ADA area of the Day Program have sufficient staff for continual training opportunities and/or choices of leisure activities through Day Program Observation visit will be done every two weeks for the next 6 months .</li> <li>· Observations will be reviewed</li> </ul>	12/20/2015			

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	<p>11/13/15 at 1:15 PM, DP staff #2:            ___ Indicated according to the activity schedule the clients were to be watching a movie.            ___ Stated, "I'm not sure what's wrong with the TV (television) but we couldn't get it to work."            ___ Indicated there were three rows of tables and one staff and eight clients for each row of tables.</p> <p>During interview with the Day Program Manager (DPM) on 11/13/15 at 1:30 PM, the DPM:            ___ Stated the DP had two rooms and the room client #3 was in was intended for "lower functioning" clients.            ___ Indicated the staffing ratio was one staff to eight clients.            ___ Stated, "I never did understand our ratio because other programs I've visited had a lower ratio of staff to clients."            ___ Stated they were short staffed at the present time as one of their staff was out "on FML (Family Medical Leave)."            ___ Indicated the DP had several clients that required assistance with toileting and/or had to have their adult briefs changed every one to two hours and had clients that required assistance with tube feedings.            ___ Stated, "It's hard for the staff because by the time they finish toileting clients and doing what they have to do, it's time</p>		<p>for compliance at monthly IDT's and Professional Quarterly Review meeting.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b>            All South B clients in the ADA area at Day Program have the potential to be affected.            ·McSherr will ensure that all South B clients in the ADA area of the Day Program have sufficient staff for continual training opportunities and/or choices of leisure activities through Day Program Observation visit will be done every two weeks for the next 6 months .            ·Observations will be reviewed for compliance at monthly IDT's and Professional Quarterly Review meeting.</p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b>            ·McSherr will ensure that all South B clients in the ADA area of the Day Program have sufficient staff for continual training opportunities and/or choices of leisure activities through Day Program            ·Observation visits will be done every two weeks for the next 6</p>				

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	<p>to start all over again."            __ Indicated the day program had an activity schedule the staff were to be following.            __ Indicated the staff were to be actively involved with the clients at all times.            __ Indicated when clients were sitting and not engaged in an activity the staff were to provide choices of activities at least every 15 minutes.</p> <p>During interview with DP staff #1 on 11/13/15 at 1:50 PM, DP staff #1:            __ Stated, "Yes, I would say we are short staffed."            __ Indicated there were several clients that required hands on assistance from the staff and stated, "The clients in here are lower functioning and require more assistance."            __ Indicated when clients were not engaged in an activity the staff were to offer them a choice of activities every 15 minutes and stated, "But that's hard to do when we have so many (clients) that require assistance to the bathroom or have to be changed."</p> <p>During interview with DP staff #3 on 11/13/15 at 1:55 PM, DP staff #3 stated the clients in the room were "lower functioning" clients and the day program did not have enough staff to provide continual interaction and active treatment</p>		<p>month .            · Observations will be reviewed for compliance at monthly IDT's and Professional Quarterly Review meeting.</p> <p><b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur (quality assurance program, etc.) and how will it be put into place?</b>            · Observation visits will be done every two weeks for the next 6 month .            · Observations will be reviewed for compliance at monthly IDT's and Professional Quarterly Review meeting.            · Residential Administrator, QIDP, SSC, and HSC will monitor through review of Day Program Observation Logs at Monthly IDT and Professional Quarterly Review</p> <p><b>What is the date by which the systemic changes will be completed?</b> 12/20/2015</p> <p><b>Respectfully Submitted,            Rosemary Taylor, Residential Administrator</b></p>				

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W 0125 Bldg. 00	<p>for the level of care the clients in the room required.</p> <p>9-3-1(a)</p> <p>483.420(a)(3) <b>PROTECTION OF CLIENTS RIGHTS</b> The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, interview and record review for 1 of 4 sampled clients (#2), the facility failed to ensure client #2's rights by not ensuring a representative to assist him in making informed decisions in regard to his medical and psychological needs.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 11/4/15 between 3:45 PM and 6 PM and on 11/5/15 between 6 AM and 8 AM.</p> <p>__ During the observation period of 11/4/15 client #2 spoke of wanting money and expressed a desire to buy alcohol. Client #2 stated, "I'm an alcoholic, do you know how I can get</p>	W 0125	<p><b>Name and Address of Provider:</b> McSherr, Inc., 4412 So. B. Street, Richmond, IN</p> <p><b>Date Survey Completed:</b> 12/3/15</p> <p><b>Provider Identification Number:</b> 15G457</p> <p><b>Survey Event ID:</b> DYHD11</p> <p><b>Finding: W125</b>– The facility failed to ensure client #2's rights by not ensuring a representative to assist him in making informed decisions in regard to his medical and psychological needs</p> <p><b>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice?</b> ·McSherr delivered paperwork completed by Primary Care Physician to Achieva Resources</p>	12/20/2015

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	<p>some alcohol around here?" At 5:45 PM client #2 had finished his evening meal, got up from the dining room table and sat down in one of the recliners in the living room. When client #2 was asked how his evening meal was, client #2 yelled obscenities and became verbally aggressive with the staff.</p> <p>During the observation period of 11/5/15, client #2 continued to yell at the staff and was verbally aggressive, asking for money to buy cigarettes and alcohol and refusing to go to the workshop.</p> <p>Client #2's record was reviewed on 11/9/15 at 12 PM. Client #2's record indicated client #2 was admitted to the facility on 7/20/15 and had diagnoses of, but not limited to, Mild Intellectual Disability, Depression, Organic Mood Disorder, Psychosis, Schizoaffective Disorder, ETOH (Ethyl Alcohol) Dependence and Cerebral Palsy.</p> <p>Client #2's 8/4/15 Behavior Support Plan (BSP) indicated client #2 had targeted behaviors of verbal aggression and non cooperation.</p> <p>Client #2's physician's orders dated 10/19/15 indicated client #2 received the following medications daily for behavior modification: Zoloft (an antidepressant) 25 mg (milligrams) and Perphenazine (an</p>		<p>on 12/9/15 to apply forguardianship for consumer #2 to ensure consumer #2 is provided a representativeto assist him in making informed decisions.</p> <p><b>Howwill you identify other residents having the potential to be affected by thesame deficient practice and what corrective action will be taken?</b></p> <p>All consumers have the potential to beaffected.</p> <ul style="list-style-type: none"> <li>·McSherr will review need forguardianship for all McSherr consumers at Professional Quarterly Reviewmeetings</li> <li>·ProfessionalQuarterly Review meeting will review guardianship status and changing needs forall group home consumers. Applicationprocess will begin for all consumers deemed to need a guardian.</li> </ul> <p><b>Whatmeasures will be put into place or what systemic changes you will make toensure that the deficient practice does not recur?)</b></p> <ul style="list-style-type: none"> <li>·McSherr will review need for guardianshipfor all McSherr consumers at Professional Quarterly Review meetings</li> <li>·ProfessionalQuarterly Review meeting will review guardianship status and changing needs forall group home consumers.</li> </ul>				

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W 0130 Bldg. 00	<p>antipsychotic) 12 mg.</p> <p>Client #2's Social Services Assessment dated 8/18/15 indicated "[Client #2] is an emancipated adult and has no advocate or guardian at this time. However, McSherr will be requesting [name of facility] to apply to become [client #2's] legal guardian. Both of [client #2's] parents are deceased. Although he does have a brother and sister, contact or interaction with them is very minimal."</p> <p>During interview with the Qualified Intellectual Disabilities Professional (QIDP) on 11/13/15 at 3:45 PM, the QIDP:          ___ Indicated the facility had requested [name of resources] to represent client #2 as a legal guardian.          ___ Indicated the facility had found someone to represent client #2 as a legal guardian and the facility would be starting the paper work to initiate the process.</p> <p>9-3-2(a)</p> <p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all</p>		<p>Application process will begin for all consumers deemed to need a guardian.</p> <p><b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur (quality assurance program, etc.) and how will it be put into place?</b>          · Social Services Coordinator, QIDP, RA and RN will monitor through discussion at Monthly IDT          · Professional Quarterly Review meeting will review guardianship status and changing needs for all group home consumers.          Application process will begin for all consumers deemed to need a guardian.</p> <p><b>What is the date by which the systemic changes will be completed?</b> 12/20/15</p> <p><b>Respectfully Submitted,</b>  <b>Rosemary Taylor, Residential Administrator</b></p>				

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	<p>clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>Based on observation, interview and record review for 1 additional client (client #7), the facility failed to ensure client #7's rights in regard to privacy and dignity while in the restroom.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 11/4/15 between 3:45 PM and 6 PM and on 11/5/15 between 6 AM and 8 AM. Client #7 was a blind, middle aged male who was unsteady on his feet and required staff assistance for ambulation and mobilization to navigate through the home and to use the restroom. During both observation periods, the staff accompanied client #7 in and out of the bathroom and stayed with client #7 while using the restroom.</p> <p>Review of employee #13's records on 11/5/15 at 1 PM indicated a counseling record dated 8/28/15. The record indicated the "SSC (Social Services Coordinator) has been made aware of a situation where the resident's right to privacy has not always been insured by [staff #13]. It was reported that [staff #13] had [client #7] hold onto the bathroom counter while she used the</p>	W 0130	<p><b>Name and Address of Provider:</b> McSherr, Inc., 4412 So. B. Street, Richmond, IN</p> <p><b>Date Survey Completed:</b> 12/3/15</p> <p><b>Provider Identification Number:</b> 15G457</p> <p><b>Survey Event ID:</b> DYHD11</p> <p><b>Finding: W130</b>– The facility failed to ensure client #7's rights in regard to privacy and dignity while in the restroom</p> <p><b>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice?</b> Employee that violated client #7's rights in regard to privacy and dignity while in the restroom was terminated from employment with McSherr. Staff at South B Street were retrained on suspected Abuse, Neglect and Exploitation on 11/23/15 and received an Accel written reminder re: respecting Resident Rights and Ensuring Dignity on 12/10/15. Staff are required to read the reminder before being granted access to their timecards.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what</b></p>	12/20/2015

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	<p>restroom. This type of activity is inappropriate and violates the policies.... SSC was also made aware of [staff #13] leaving [client #7] in the bathroom unattended, which is in violation of policy...." The record indicated staff #13 stated, "So sorry, it will not happen again." The report indicated staff #13 will be retrained in regard to client rights and privacy. The report indicated signatures from staff #13, the HM (House Manager) and the SSC.</p> <p>Client #7's Individualized Support Plan (ISP) dated 8/23/15 indicated a diagnosis of, but not limited to, Congenital Blindness. The ISP indicated client #7 ambulated with sighted guide and required staff assistance while using the restroom.</p> <p>During interview with staff #5 on 11/5/15 at 7:30 AM, staff #5 indicated he had reported an incident of a female co-worker having client #7 hold onto the bathroom sink counter top while the female staff that was assigned to client #7 used the restroom herself with client #7 in the room. Staff #5 stated, "That was just wrong. She apparently thought since he was blind it was not a big deal."</p> <p>During interview with the SSC on 11/5/15 at 11 AM, the SSC:          ___ Indicated staff #5 reported the incident of staff #13 using the restroom in front of and while supervising client #7 to her.          ___ Stated, "I have no idea what [staff #13] was</p>		<p><b>corrective action will be taken?</b>            All consumers have the potential to beaffected.            ·All staff working in McSherr GroupHomes have been retrained on Suspected Abuse, Neglect, and Exploitation atbi-monthly house meetings and all group home staff received a written reminderto respect resident rights and ensure dignity through Accel messaging(electronic record keeping system utilized by McSherr).</p> <p><b>Whatmeasures will be put into place or what systemic changes you will make toensure that the deficient practice does not recur?)</b>            ·All staff working in McSherr GroupHomes have been retrained on Suspected Abuse, Neglect, and Exploitation atbi-monthly house meetings and all group home staff received a written reminderto respect resident rights and ensure dignity through Accel messaging (electronicrecord keeping system utilized by McSherr).</p> <p><b>Howwill the corrective action(s) be monitored to ensure the deficient practicewill not recur (quality assurance program, etc.) and how will it be put intoplace?</b>            ·SSCwill monitor by including questions related to Resident</p>				

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W 0140 Bldg. 00	<p>thinking when she did that."            ___Indicated staff #13 violated client #7's right to privacy and dignity.            ___Stated, "She (staff #13) was terminated a few months later but not because of this incident but because of another incident."            9-3-2(a)</p> <p>483.420(b)(1)(i)            CLIENT FINANCES            The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview for 1 of 4 sampled clients (#2), the facility failed to provide a full and complete accounting of the client's personal finances.            Findings include:            Client #2's Cash On Hand (COH) records were reviewed on 11/6/15 at 10:54 AM</p>	W 0140	<p>Rights on Quarterly Interview of clients and staff at each group home. RA, QIDP, RN, and SSC will discuss concerns related to interviews of staff and clients at monthly IDT. Bi-monthly house meetings will include discussion and training on Resident Rights and Ensuring Dignity in addition to ongoing bi-monthly training on Suspected Abuse, Neglect, and Exploitation.</p> <p><b>What is the date by which the systemic changes will be completed?</b> 12/20/2015</p> <p><b>Respectfully Submitted,</b>  <b>Rosemary Taylor, Residential Administrator</b></p> <p><b>Name and Address of Provider:</b>            McSherr, Inc., 4412 So. B. Street, Richmond, IN  <b>Date Survey Completed:</b>            12/3/2015  <b>Provider Identification Number:</b>            15G457  <b>Survey Event ID:</b> DYHD11  <b>Finding: W140</b>– The facility failed to provide a full and complete accounting of the client #2's personal finances</p>	12/20/2015	

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	<p>with the Home Manager (HM).</p> <p>Client #2's COH records indicated client #2 was given pocket money on the following days with no record of a written receipt or a "cash-out slip" with the staff's signature and/or client #2's signature to verify the client received the money: 10/30/15 - \$10.00 11/06/15 - \$5.00.</p> <p>Review of the facility's policy (no date) titled "Consumer Funds Management" on 11/6/15 at 11 AM indicated "When funds are removed from the cash on hand for any purpose, a cash-out slip is placed in the pouch showing the date, the amount and the intended purpose and is signed by the employee receiving the money."</p> <p>During interview with the HM on 11/6/15 at 11:05 AM, the HM: __ Indicated the cash removed for pocket money for client #2 on 10/30/15 and 11/6/15 did not have a receipt and/or cash-out slip. __ Indicated the staff should have signed a receipt of removal of the money from the COH and the client should have signed he received the money.</p> <p>9-3-2(a)</p>		<p><b>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice?</b></p> <p>·Consumer #2's finances will include signature/initials of consumer and/or staff on receipt when consumer #2 is given spending money from his personal finances. <b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <p>All consumers have the potential to be affected. ·All group home managers (the only staff with access to client funds) have been instructed to get client/staff signatures/initials on all receipts for cash given to clients for spending money.</p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <p>·All group home managers (the only staff with access to client funds) have been instructed to get client/staff signatures/initials on all receipts for cash given to clients for spending money. ·Residential Administrator will review for consumer/staff signatures/initials on all receipts for spending money given to consumers from their personal</p>		

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W 0149  Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview for 3 of 4 sampled clients (#1, #2, and #4) and 4 additional clients (#5, #6, #7 and #8), the facility failed to implement its policy and procedures to	W 0149	funds  <b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur (quality assurance program, etc.) and how will it be put into place?</b> · All group home managers (the only staff with access to client funds) have been instructed to get client/staff signatures/initials on all receipts for cash given to clients for spending money · Residential Administrator will review for consumer/staff signatures/initials on all receipts for spending money given to consumers from their personal funds  <b>What is the date by which the systemic changes will be completed?</b> 12/20/2015  <b>Respectfully Submitted,</b> <b>Rosemary Taylor, Residential Administrator</b>  <b>Name and Address of Provider:</b> McSherr, Inc., 4412 So. B. Street, Richmond, IN <b>Date Survey Completed:</b> 12/3/2015 <b>Provider Identification Number:</b> 15G457	12/20/2015	

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	<p>prevent the abuse/neglect of clients #1, #2, #4, #5, #6, #7 and #8.</p> <p>__To prevent the neglect of client #4 resulting in a medication overdose.</p> <p>__To prevent the neglect of clients #1, #2, #5, #6 and #8 in regard to ensuring sufficient staffing while in the community.</p> <p>__To prevent the abuse/neglect of client #7 in regard to personal privacy and client rights for client #7.</p> <p>__To ensure the facility staff reported all allegations of abuse/neglect immediately to the administrator for clients #1, #2, #4, #5, #6, #7 and #8.</p> <p>__To ensure all allegations of abuse/neglect were reported to the Bureau of Developmental Disabilities Services (BDDS) per IAC 9-3-1(b)(5) and Adult Protective Services (APS) per IC 12-10-3 according to state law for clients #1, #2, #4, #5, #6, #7 and #8.</p> <p>__To ensure all allegations of abuse/neglect were investigated for clients #1, #2, #4, #5, #6, #7 and #8.</p> <p>Findings include:</p> <p>1. The facility's reportable and investigative records were reviewed on 11/4/15 at 2:30 PM. The 2/4/15 BDDS report indicated the Social Service Coordinator (SSC) received a report on 2/4/15. The report indicated client #4 had</p>		<p><b>SurveyEvent ID:</b> DYHD11</p> <p><b>Finding: W149</b>– The facility neglected to implement its policy and proceduresto prevent the abuse/neglect of clients #1, #2, #3, #4, #5, #6, #7, and #8 andto:</p> <p>__Ensure allallegations of neglect were immediately reported to BDDS(Bureau of Developmental Disabilities Services) per IAC9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according tostate law for clients #1, #2, #4, #5, #6, #7., and #8.</p> <p>__Prevent the neglect of client #4 resultingin a medication overdose</p> <p>__Prevent theabuse/neglect of client #7 in regard to personal privacy and client rights forclient #7</p> <p>__Prevent theneglect of clients #1, #2, #5, #6, and #8 in regard to ensuring sufficientstaffing while in the community</p> <p>__Ensure thefacility staff reported all allegations of abuse/neglect immediately to theadministrator for clients #1, #2, #4, #5, #6, #7, and #8</p> <p>__Ensure allallegations of abuse/neglect were investigated for clients #1, #2, #4, #5, #6,#7, and #8</p> <p><b>Whatcorrective action(s) will be accomplished for these residents found to havebeen affected by the deficient practice?</b></p> <p>·Allallegations of neglect and/or</p>	

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	<p>stated on 1/28/15 to staff #12 that client #4 was burned with hot water while staff #11 was giving her a shower and on 1/30/15 staff #12 observed staff #11 giving client #4 peanut butter on a cracker which was not on client #4's diet due to client #4 having Dysphasia (difficulty swallowing). The report indicated an investigation was conducted from 2/4/15 to 2/6/15 by the SSC.</p> <p>During interview with staff #12, staff #12 indicated:            ___ Client #4 stated staff #11 "burned me in the shower. I was all red and it hurt."            ___ She (staff #12) had "heard through the grape vine" one of the new staff had said client #4 "was really red when she came out of the bathroom."            ___ In staff #12's original report staff #11 had admitted to staff #12 that she had burned client #4 in the shower and said client #4 was "really red and was saying the water was hot."            ___ Client #4 refused her shower on the 1/28/15 and this incident "supposedly happened on the 27th, but I was not there."            ___ The only time she had seen peanut butter given to client #4 was on 1/30/15 when staff #11 put peanut butter on a cracker and gave it to client #4 and stated staff #11 said, "I know she (client #4) is not supposed to have this, oh well."</p>		<p>abuse, including medication errors, violation of resident rights, injuries of unknown origin, and insufficient staff ratio, will be immediately reported to the administrator, BDDS, and APS per regulations, state law, and McSherr policy and will be investigated per policy and regulations.</p> <ul style="list-style-type: none"> <li>· All investigations of neglect or abuse, will include a specific plan of corrective oversight that will include how McSherr staff will be monitored to prevent recurrence (this includes adding a 6a-9a position so night shift staff do not have to administer medications when they are tired).</li> <li>· Staff were retrained on Suspected Abuse, Neglect, and Exploitation and Incident Reporting on 11/23/15.</li> <li>· Bi-Monthly house meetings will include sections on Resident Rights as well as Abuse and Neglect.</li> </ul> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b>            All Consumers have the potential to be affected            · All allegations of neglect and/or abuse, including medication errors, violation of resident rights, injuries of unknown origin, and insufficient staff ratio, will be</p>	

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	<p>During interview with staff #6, staff #6 indicated:            __ Client #4 had told her that someone had burned her in the shower but did not specify which staff it was.            __ Client #4 had refused to take a shower the night of 1/28/15. On the morning of 1/29/15 staff #6 asked client #4 why she had slept in her clothes all night and client #4 stated, "I'm not going to take a bath because that girl burnt me. She kept going on about that girl burned her and I asked her what girl. She closed her mouth and shook her head no."</p> <p>During interview with staff #10, staff #10 indicated:            __ On 1/29/15 when staff #10 and staff #2 tried to get client #4 in the shower client #4 refused to get in and stated "Water burn me. No more showers. Water is too hot."            __ When the 3rd shift staff (#8) came in on 1/29/15 she (staff #8) indicated client #4 was red on Wednesday night when she came in to work.            __ "[Client #4] was always ready for a shower, but now is not and she (staff #10) has seen a change in her."            __ Stated she had seen staff #11 giving client #4 potato chips, [a brand name of snack chip] and [a brand name of dry cereal] and asked if client #4 can have the</p>		<p>immediately reported to the administrator, BDDS, and APS per regulations, state law, and McSherr policy and will be investigated per policy and regulations.</p> <ul style="list-style-type: none"> <li>· All investigations of neglect or abuse, will include a specific plan of corrective oversight that will include how McSherr staff will be monitored to prevent recurrence (this includes adding a 60-9a position so night shift staff do not have to administer meds when they are tired).</li> <li>· Staff were retrained on Suspected Abuse, Neglect, and Exploitation and Incident Reporting on 11/23/15.</li> <li>· Bi-Monthly house meetings will include sections on Resident Rights and Incident Reporting as well as Abuse and Neglect</li> <li>· SSC quarterly interviews of staff and clients asking if they have any concerns of suspected abuse and neglect will now include specific questions relating to resident rights and incident reporting</li> <li>· Professional Quarterly Review will include discussion of all investigations. PQR is comprised of QIDP, Social SC, HSC, and Residential Administrator</li> </ul> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>· All investigations of neglect or</li> </ul>	

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	<p>dry cereal and was told yes.</p> <p>The report indicated "All staff that stated they had seen or heard things will receive disciplinary action per McSherr's disciplinary policy. All McSherr staff will be re-trained on McSherr's policy concerning suspected Abuse/Neglect."</p> <p>The report indicated the staff failed to report allegations of abuse and neglect immediately to the administrator.</p> <p>During interview with the Administrator (Adm) on 11/4/15 at 2:30 PM, the Adm indicated all allegations of abuse/neglect were to be reported immediately to the Adm and to BDDS and APS as per state law within 24 hours of knowledge of the abuse/neglect.</p> <p>2. The facility's reportable and investigative records were reviewed on 11/4/15 at 2:30 PM. The 6/23/15 BDDS report indicated "It was brought to the SSC's attention on 6/17/15 that a staff person had made a phone call to State reporting abuse happening at McSherr's [name of street] group home. This report did not indicate who the victim was or who the perpetrator was. The SSC started an internal investigation into this general report. However, during the investigation staff member (#7) was indicated as</p>		<p>abuse, will include a specific plan of correctiveoversight that will include how McSherr staff will be monitored to preventrecurrence (this includes adding a 6a-9a position so night shift staff do nothave to administer meds when they are tired).</p> <ul style="list-style-type: none"> <li>·Staff were retrained on SuspectedAbuse, Neglect, and Exploitation and Incident Reporting on 11/23/15.</li> <li>·Bi-Monthlyhouse meetings will include sections on Resident Rights and Incident Reportingas well as Abuse and Neglect</li> <li>·SSCquarterly interviews of staff and clients asking if they have any concerns ofsuspected abuse and neglect will now include specific questions relating toresident rights and incident reporting and reports will be reviewed monthly atIDT</li> <li>·ProfessionalQuarterly Review will include discussion of all investigations. PQR is comprised of QIDP, Social ServicesCoordinator, Health Services Coordinator, and Residential Administrator</li> </ul> <p><b>Howwill the corrective action(s) be monitored to ensure the deficient practicewill not recur (quality assurance program, etc.) and how will it be put intoplace?</b></p> <ul style="list-style-type: none"> <li>·Allinvestigations of neglect or abuse, will include a specific plan of correctiveoversight that will include how McSherr staff will be</li> </ul>		

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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	
	<p>yelling at consumers [#5 and #8]. [Staff #7] was immediately suspended on 6/19/15 when her name came up during the investigation." The report indicated an investigation was conducted from 6/17/15 through 6/22/15 by the SSC.</p> <p>The report included staff interviews by the SSC.</p> <p>During interview with staff #6, staff #6: ___ Indicated she had heard a co-worker yelling at clients #5 and #8.</p> <p>___ Stated, "When I came into work, she (staff #7) was in the med (medication) room yelling for [client #5] and he (client #5) was in his room with the door closed. Then she (staff #7) yelled down the hallway to [client #8] to go to the med room."</p> <p>___ Indicated staff #7 got up, threw books on the table and stated, "[Client #4] and I got in a fight with the shower curtain and I got soaked."</p> <p>___ Indicated staff #7 was not passing medications at the time and indicated that was why she (staff #6) did not understand why staff #7 was "yelling at the consumers."</p> <p>During interview with staff #9, staff #9 indicated she had heard staff #7 was screaming while helping a resident with a bath and staff #10 was upset by it (staff screaming at the clients).</p>		<p>monitored to prevent recurrence(this includes adding a 6a-9a position so night shift staff do not have to administer meds when they are tired).</p> <ul style="list-style-type: none"> <li>·Accident&amp; Injury reports are reviewed by Professional Quarterly Review to determineif an investigation should have been done.</li> <li>·ProfessionalQuarterly Review will include discussion of all investigations. PQR is comprised of QIDP, Social ServicesCoordinator, Health Services Coordinator, and Residential Administrator</li> <li>·SocialServices Coordinator will monitor through quarterly interview of consumers andstaff to determine if there are any deficiencies in services, including abuse, neglect, or violation of resident rights.</li> </ul> <p><b>What is the date by which the systemic changes will be completed? 12/20/15</b></p> <p><b>RespectfullySubmitted, RosemaryTaylor, Residential Administrator</b></p>		

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	<p>During interview with staff #10, staff #10 indicated she had heard client #4 yelling and stated "On Thursday June 11, 2015, I (staff #10) worked with [staff #7], from the beginning of the shift, she (staff #7) let me know, that she was leaving at 9:00 PM because she had a date. [Staff #7] would start lunches, then walk away and start something else. She mentioned her date several times, stated that there was no way that she was going to get off on time. She stated that we needed three staff so that she could go outside. I (staff #10) asked her several times to go out if she needed to. [Staff #7] kept asking what time the staff meeting was for the next day. She asked several times what consumers she had. I asked her not to leave until the buddy check was done. Two consumers behaviors could have been avoided if she hadn't been so high strung and wanting to rush through everything."</p> <p>The 6/23/15 report indicated "A peer review met on 6/23/15 and discussed the results of the investigation. After discussion of the investigation, the peer review concluded that there was a preponderance of evidence to support those allegations of verbal abuse. Therefore, [staff #7's] employment with McSherr is terminated as of 06/23/2015."</p>			

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	<p>The report indicated all staff that worked at the home would be re-trained in regard to suspected Abuse/Neglect.</p> <p>The report indicated the staff failed to report allegations of abuse immediately to the administrator.</p> <p>During interview with the Administrator (Adm) on 11/4/15 at 2:30 PM, the Adm indicated all allegations of abuse/neglect were to be reported immediately to the administrator and to BDDS and APS as per state law within 24 hours of knowledge of the abuse/neglect.</p> <p>3. The facility's reportable and investigative records were reviewed on 11/4/15 at 2:30 PM. The 8/4/15 BDDS report indicated on 8/3/15 between 7 AM and 7:30 AM, staff was passing the morning meds. "[Client #4] was the last resident to receive her morning meds. As the staff was checking off [client #4's] medicine in the med book she (the staff) realized that she had not only given [client #4] her morning meds but also her evening meds as well. Staff called Mesherr's HSC (Health Services Coordinator/RN) and reported the med error. According to staff, she (the staff) stated she was very tired and that was the reason she made the med error. HSC went to the group home and spoke with</p>			

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	<p>staff and [client #4]. Assessed [client #4]; V/S (vital signs) stable, appeared drowsy but alert. HSC phoned [client #4's NP's] office to report medication error and to get orders. Received the following orders during the same phone call: Watch for sedation and not to give any of her (client #4's) routine medications this evening and resume medications in the morning. [Client #4] was kept home from day programming and placed on standby assistance today. Staff was to keep her in line of sight and if it was noticed that she was going to stand up, staff were to accompany her until she was seated again due to possible dizziness. Staff were also informed to take client #4's V/S (vital signs): BP (blood pressure), P (pulse), O2 (pulse oximeter/oxygen saturation in the blood) sat hourly until 10 PM today."</p> <p>The 8/6/15 Follow Up BDDS report indicated client #4 did not experience any adverse side-effects from the medication error and her vital signs and level of consciousness were monitored for twelve hours following the error. The staff member that made the error was suspended from passing medications until the staff was retrained on basic medication administration.</p> <p>Client #4's record was reviewed on 11/9/15 at 3 PM.</p>			

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	<p>Client #4's Medication Administration Records (MARs) for August 2015 indicated on 8/3/15 client #4 was to receive the following medications in the AM:</p> <p>Digoxin 125 mcg (micrograms) for tachycardia (a fast heart rhythm). Zyrtec 10 mg (milligrams) for allergies. Bisoprolol-HCTZ 2.5-6.25 (half tab) for high blood pressure. Klonopin 0.5 mg (half tab) for behavior control. Cran (Cranberry)-max 500 mg (a dietary supplement). Miralax 17 gm (grams) for constipation. Oys (Oyster) Cal+D 500/200 (a dietary supplement). Oxybutynin 5 mg for an overactive bladder. Fiber-Lax 2 caps (a dietary supplement). Pepcid 20 mg for indigestion.</p> <p>Client #4's MARs for August 2015 indicated on 8/3/15 client #4 was to receive the following medications in the PM:</p> <p>Oxybutynin 5 mg. Oys Cal+D 500/200. Fiber-Lax 2 caps. Pepcid 20 mg. Colace 100 mg for constipation. Seroquel XR 150 mg for behavior control. Haldol 10 mg for behavior control.</p>			

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	<p>During interview with the SSC on 11/5/15 at 11 AM, the SSC:            ___ Stated, "We didn't conduct an official investigation."            ___ Indicated the RN spoke with the staff that made the error.            ___ Indicated at the time of the incident she did not look at the incident as neglect or abuse.            ___ Stated, "In looking back, due to the severity of the error, I should have done an investigation."</p> <p>Email interview with the HSC/RN on 11/20/15 at 11:28 AM indicated:            ___ Indicated two staff worked the overnight shift from 9 PM to 9 AM.            ___ Indicated staff #8 had worked the overnight shift and was the one that made the error.            ___ Indicated "I questioned the staff (#8) that administered morning and evening doses. She received a counseling. Her response to what had happened to cause this error was 'I was tired and not feeling well on this day.' [Staff #8] did not contact her supervisor to inform that she was tired or not feeling well."            ___ Indicated staff #8 did not tell her supervisor she was tired and/or that she did not feel well.            ___ Stated "One staff person comes in from 6 AM to 9 AM. On that particular</p>			

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	<p>day due to the census of 6 consumers, there was no 6 AM to 9 AM staff assigned."          __ Stated "Staff has since been added not only because of the increase in census but also due to the med error incident."</p> <p>4. Observations were conducted at the group home on 11/4/15 between 3:45 PM and 6 PM and on 11/5/15 between 6 AM and 8 AM. Client #7 was a blind, middle aged male who was unsteady on his feet and required staff assistance for ambulation and mobilization to navigate through the home and to use the restroom. During both observation periods, the staff accompanied client #7 in and out of the bathroom and stayed with client #7 while using the restroom.</p> <p>Review of employee #13's records on 11/5/15 at 1 PM indicated a counseling record dated 8/28/15. The record indicated the "SSC has been made aware of a situation where the resident's right to privacy has not always been insured by [staff #13]. It was reported that [staff #13] had [client #7] hold onto the bathroom counter while she used the restroom. This type of activity is inappropriate and violates the policies.... SSC was also made aware of [staff #13] leaving [client #7] in the bathroom unattended, which is in violation of</p>				

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	<p>policy...." The record indicated staff #13 stated, "So sorry, it will not happen again." The report indicated staff #13 will be retrained in regard to client rights and privacy. The report indicated signatures from staff #13, the HM (House Manager) and the SSC.</p> <p>The facility's reportable and investigative records were reviewed on 11/4/15 at 2:30 PM. The facility records indicated the allegation of neglect/abuse of client #7 by staff #13 recorded in the counseling of 8/28/15 was not reported immediately to the administrator and/or reported to BDDS and/or APS as per state law. The facility records indicated no investigation was conducted in regard to the allegation of neglect/abuse of client #7 by staff #13.</p> <p>During interview with staff #5 on 11/5/15 at 7:30 AM, staff #5 indicated he had reported an incident of a female co-worker having client #7 hold onto the bathroom sink counter top while the female staff that was assigned to client #7 used the restroom herself with client #7 in the room. Staff #5 stated, "That was just wrong. She apparently thought since he was blind it was not a big deal." Staff #5 indicated he heard this from another co-worker and asked the co-worker if it had been reported. The co-worker told staff #5 "Not that they were aware of."</p>				

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	<p>Staff #5 indicated he reported the allegation immediately to the SSC upon hearing this.</p> <p>During interview with the SSC on 11/5/15 at 11 AM, the SSC:</p> <p>__ Indicated staff #5 reported the incident of staff #13 using the restroom in front of and while supervising client #7.</p> <p>__ Indicated the allegation of abuse/neglect was not reported to BDDS or APS nor was an investigation conducted.</p> <p>__ Indicated no written verification the administrator was notified of the allegation of abuse/neglect.</p> <p>__ Indicated staff #13 was counseled and was retrained in regard to client privacy and rights.</p> <p>__ Indicated at the time of the incident she did not look at it as neglect or abuse and stated, "I was just so taken back by the whole thing, I didn't even think about abuse or neglect at the time. I guess I should have."</p> <p>__ Stated, "She (staff #13) was terminated a few months later but not because of this incident but because of another incident."</p> <p>5. The facility's reportable and investigative records were reviewed on 11/4/15 at 2:30 PM. The 9/9/15 BDDS report indicated "On 9/9/15 it was reported and substantiated that [staff #13]</p>			

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	<p>transported five residents [clients #1, #2, #5, #6 and #8) to the park on Sunday, September 6, 2015 with no other staff present. This outing was not approved by the House Manager and jeopardized the residents' safety with a staffing ratio of 1:5." The report indicated staff #13's employment with the facility was terminated on 9/10/15 and "All staff that had firsthand knowledge of this incident or had heard of this incident and did not report it immediately, which McSherr policy requires, received disciplinary action per McSherr's Disciplinary policy and BDDS regulations on incident reporting."</p> <p>The facility investigative records indicated no investigation in regard to the allegation of neglect to ensure sufficient staff supervision for clients #1, #2, #5, #6 and #8 on 9/6/15 when taken out into the community.</p> <p>During interview with the SSC on 11/5/15 at 11 AM, the SSC:            ___ Indicated two staff were working in the home on 9/6/15.            ___ Indicated there was a ratio of one staff to two clients when going out into the community.            ___ Indicated the staff failed to provide sufficient staffing and supervision for clients #1, #2, #5, #6 and #8 on 9/6/15.</p>			

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	<p>___Indicated the staff working that day failed to report the outing and all staff aware of the incident should have reported it immediately.</p> <p>___Indicated there was no investigation in regard to the allegation of staff neglect to ensure sufficient staffing while taking the clients out into the community.</p> <p>Review of the 2014 revised facility policy "MCSHERR, INC. INVESTIGATIONS and SUSPECTED ABUSE NEGLECT OR EXPLOITATION" on 11/4/15 at 2 PM indicated any "alleged, suspected, or actual abuse, neglect or exploitation of an individual, any violation of an individual's rights, any client to client abuse, and/or any injuries of unknown origin must be reported accordingly to Bureau of Quality Improvement Services (BQIS) within twenty-four (24) hours, while following appropriate reporting procedures." The policy indicated all alleged, suspected, or actual abuse, neglect or exploitation of an individual, any violation of an individual's rights, any client to client abuse, and/or any injuries of unknown origin was to be thoroughly investigated.</p> <p>9-3-2(a) 9-3-1(b)(5)</p>			

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W 0153 Bldg. 00	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS</p> <p>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.</p> <p>Based on observation, record review and interview for 4 of 5 allegations of abuse/neglect for clients #1, #2, #4, #5, #6, #7 and #8, the facility failed to ensure all allegations of abuse/neglect were reported immediately to the administrator and to the BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law.</p> <p>Findings include:</p> <p>1. The facility's reportable and investigative records were reviewed on 11/4/15 at 2:30 PM. The 2/4/15 BDDS report indicated the Social Service Coordinator (SSC) received a report on 2/4/15. The report indicated client #4 had stated on 1/28/15 to staff #12 that client #4 was burned with hot water while staff #11 was giving her a shower and on 1/30/15 staff #12 observed staff #11 giving client #4 peanut butter on a cracker which was not on client #4's diet</p>	W 0153	<p><b>Name and Address of Provider:</b> McSherr, Inc., 4412 So. B. Street, Richmond, IN</p> <p><b>Date Survey Completed:</b> 12/3/2015</p> <p><b>Provider Identification Number:</b> 15G457</p> <p><b>Survey Event ID:</b> DYHD11</p> <p><b>Finding: W153</b> - The facility failed to ensure all allegations of neglect were immediately reported to BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law for clients #1, #2, #4, #5, #6, #7., and #8.</p> <p><b>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice?</b> · All allegations of neglect and/or abuse, including medication errors, violation of resident rights, injuries of unknown origin, and insufficient staff ratio, will be immediately reported to the administrator, BDDS, and APS</p>	12/20/2015

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	<p>due to client #4 having Dysphasia (difficulty swallowing). The report indicated an investigation was conducted from 2/4/15 to 2/6/15 by the SSC. The report included staff interviews by the SSC.</p> <p>During interview with staff #12, staff #12 indicated:            __ Client #4 stated staff #11 "burned me in the shower. I was all red and it hurt."            __ She (staff #12) had "heard through the grape vine" one of the new staff had said client #4 "was really red when she came out of the bathroom."            __ In staff #12's original report staff #11 had admitted to staff #12 that she had burned client #4 in the shower and said client #4 was "really red and was saying the water was hot."            __ Client #4 refused her shower on the 1/28/15 and this incident "supposedly happened on the 27th, but I was not there."            __ The only time she had seen peanut butter given to client #4 was on 1/30/15 when staff #11 put peanut butter on a cracker and gave it to client #4 and stated staff #11 said, "I know she (client #4) is not supposed to have this, oh well."</p> <p>During interview with staff #6, staff #6 indicated:            __ Client #4 had told her that someone</p>		<p>per regulations, state law, and McSherr policy and will be investigated per policy and regulations.</p> <ul style="list-style-type: none"> <li>· All investigations of neglect or abuse, will include a specific plan of corrective oversight that will include how McSherr staff will be monitored to prevent recurrence (this includes adding a 6a-9a position so night shift staff do not have to administer medications when they are tired).</li> <li>· Staff were retrained on Suspected Abuse, Neglect, and Exploitation and Incident Reporting on 11/23/15.</li> <li>· Bi-Monthly house meetings will include sections on Resident Rights as well as Abuse and Neglect</li> <li>· SSC quarterly interviews of staff and clients asking if they have any concerns of suspected abuse and neglect will now include specific questions relating to resident rights and incident reporting. Questions will now be more "open ended" requiring staff and clients to answer in more detail instead of being able to answer with a yes or no.</li> </ul> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b>            All Consumers have the potential to be affected            · All allegations of neglect and/or</p>		

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	<p>had burned her in the shower but did not specify which staff it was.</p> <p>__ Client #4 had refused to take a shower the night of 1/28/15. On the morning of 1/29/15 staff #6 asked client #4 why she had slept in her clothes all night and client #4 stated, "I'm not going to take a bath because that girl burnt me. She kept going on about that girl burned her and I asked her what girl. She closed her mouth and shook her head no."</p> <p>During interview with staff #10, staff #10 indicated: __ On 1/29/15 when staff #10 and staff #2 tried to get client #4 in the shower client #4 refused to get in and stated "Water burn me. No more showers. Water is too hot." __ When the 3rd shift staff (#8) came in on 1/29/15 she (staff #8) indicated client #4 was red on Wednesday night when she came in to work. __ "[Client #4] was always ready for a shower, but now is not and she (staff #10) has seen a change in her." __ Stated she had seen staff #11 giving client #4 potato chips, [a brand name of snack chip] and [a brand name of dry cereal] and asked if client #4 can have the dry cereal and was told yes.</p> <p>The report indicated the staff failed to report allegations of abuse and neglect</p>		<p>abuse, including medication errors, violation of resident rights, injuries of unknown origin, and insufficient staff ratio, will be immediately reported to the administrator, BDDS, and APS per regulations, state law, and McSherr policy and will be investigated per policy and regulations.</p> <ul style="list-style-type: none"> <li>· All investigations of neglect or abuse, will include a specific plan of corrective oversight that will include how McSherr staff will be monitored to prevent recurrence (this includes adding a 60-9a position so night shift staff do not have to administer meds when they are tired).</li> <li>· Staff were retrained on Suspected Abuse, Neglect, and Exploitation and Incident Reporting on 11/23/15.</li> <li>· Bi-Monthly house meetings will include sections on Resident Rights and Incident Reporting as well as Abuse and Neglect</li> <li>· SSC quarterly interviews of staff and clients asking if they have any concerns of suspected abuse and neglect will now include specific questions relating to resident rights and incident reporting. Questions will now be more "open ended" requiring staff and clients to answer in more detail instead of being able to answer with a yes or no.</li> <li>· Professional Quarterly Review will include discussion of all investigations. PQR is comprised of QIDP, Social SC, HSC,</li> </ul>		

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	<p>immediately to the administrator. The report indicated "All staff that stated they had seen or heard things will receive disciplinary action per McSherr's disciplinary policy. All McSherr staff will be re-trained on McSherr's policy concerning suspected Abuse/Neglect."</p> <p>During interview with the administrator on 11/4/15 at 2:30 PM, the administrator indicated all allegations of abuse/neglect were to be reported immediately to the administrator and to BDDS and APS as per state law within 24 hours of knowledge of the abuse/neglect.</p> <p>2. The facility's reportable and investigative records were reviewed on 11/4/15 at 2:30 PM. The 6/23/15 BDDS report indicated "It was brought to the SSC's attention on 6/17/15 that a staff person had made a phone call to State reporting abuse happening at McSherr's [name of street] group home. This report did not indicate who the victim was or who the perpetrator was. The SSC started an internal investigation into this general report. However, during the investigation staff member (#7) was indicated as yelling at consumers [#5 and #8]. [Staff #7] was immediately suspended on 6/19/15 when her name came up during the investigation." The report indicated an investigation was conducted from</p>		<p>andResidential Administrator</p> <p><b>Whatmeasures will be put into place or what systemic changes you will make toensure that the deficient practice does not recur?)</b></p> <ul style="list-style-type: none"> <li>·Allinvestigations of neglect or abuse, will include a specific plan of correctiveoversight that will include how McSherr staff will be monitored to preventrecurrence (this includes adding a 6a-9a position so night shift staff do nothave to administer meds when they are tired).</li> <li>·Staff were retrained on SuspectedAbuse, Neglect, and Exploitation and Incident Reporting on 11/23/15.</li> <li>·Bi-Monthlyhouse meetings will include sections on Resident Rights and Incident Reportingas well as Abuse and Neglect</li> <li>·SSCquarterly interviews of staff and clients asking if they have any concerns ofsuspected abuse and neglect will now include specific questions relating toresident rights and incident reporting. Questions will now be more "open ended" requiring staff and clients toanswer in more detail instead of being able to answer with a yes or no. Reportswill be reviewed monthly at IDT</li> <li>·ProfessionalQuarterly Review will include discussion of all investigations. PQR is comprised of QIDP, Social ServicesCoordinator, Health</li> </ul>				

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	<p>6/17/15 through 6/22/15 by the SSC. The report included staff interviews by the SSC.</p> <p>During interview with staff #6, staff #6: ___ Indicated she had heard a co-worker yelling at clients #5 and #8. ___ Stated, "When I came into work, she (staff #7) was in the med (medication) room yelling for [client #5] and he (client #5) was in his room with the door closed. Then she (staff #7) yelled down the hallway to [client #8] to go to the med room." ___ Indicated staff #7 got up, threw books on the table and stated, "[Client #4] and I got in a fight with the shower curtain and I got soaked." ___ Indicated staff #7 was not passing medications at the time and indicated that was why she (staff #6) did not understand why staff #7 was "yelling at the consumers."</p> <p>During interview with staff #9, staff #9 indicated she had heard staff #7 was screaming while helping a resident with a bath and staff #10 was upset by it (staff screaming at the clients).</p> <p>During interview with staff #10, staff #10 indicated she had heard client #4 yelling and stated "On Thursday June 11, 2015, I (staff #10) worked with [staff #7], from</p>		<p>Services Coordinator, and Residential Administrator</p> <p><b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur (quality assurance program, etc.) and how will it be put into place?</b></p> <ul style="list-style-type: none"> <li>· All investigations of neglect or abuse, will include a specific plan of corrective oversight that will include how McSherr staff will be monitored to prevent recurrence (this includes adding a 6a-9a position so night shift staff do not have to administer meds when they are tired).</li> <li>· Accident &amp; Injury reports are reviewed by Professional Quarterly Review to determine if an investigation should have been done.</li> <li>· Professional Quarterly Review will include discussion of all investigations. PQR is comprised of QIDP, Social Services Coordinator, Health Services Coordinator, and Residential Administrator</li> <li>· SSC quarterly interviews of staff and clients asking if they have any concerns of suspected abuse and neglect will now include specific questions relating to resident rights and incident reporting. Questions will now be more "open ended" requiring staff and clients to answer in more detail instead of being able to answer with a yes or no. Reports will be reviewed monthly at IDT</li> </ul>				

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	<p>the beginning of the shift, she (staff #7) let me know, that she was leaving at 9:00 PM because she had a date. [Staff #7] would start lunches, then walk away and start something else. She mentioned her date several times, stated that there was no way that she was going to get off on time. She stated that we needed three staff so that she could go outside. I (staff #10) asked her several times to go out if she needed to. [Staff #7] kept asking what time the staff meeting was for the next day. She asked several times what consumers she had. I asked her not to leave until the buddy check was done. Two consumers behaviors could have been avoided if she hadn't been so high strung and wanting to rush through everything."</p> <p>The report indicated the facility staff failed to report allegations of abuse immediately to the administrator.</p> <p>During interview with the administrator on 11/4/15 at 2:30 PM, the administrator indicated all allegations of abuse/neglect were to be reported immediately to the administrator and to BDDS and APS as per state law within 24 hours of knowledge of the abuse/neglect.</p> <p>3. Observations were conducted at the group home on 11/4/15 between 3:45 PM</p>		<p><b>What is the date by which the systemic changes will be completed? 12/20/15</b></p> <p><b>Respectfully Submitted, Rosemary Taylor, Residential Administrator</b></p>		

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	<p>and 6 PM and on 11/5/15 between 6 AM and 8 AM. Client #7 was a blind, middle aged male who was unsteady on his feet and required staff assistance for ambulation and mobilization to navigate through the home and to use the restroom. During both observation periods, the staff accompanied client #7 in and out of the bathroom and stayed with client #7 while using the restroom.</p> <p>Review of employee #13's records on 11/5/15 at 1 PM indicated a counseling record dated 8/28/15. The record indicated the "SSC has been made aware of a situation where the resident's right to privacy has not always been insured by [staff #13]. It was reported that [staff #13] had [client #7] hold onto the bathroom counter while she used the restroom. This type of activity is inappropriate and violates the policies.... SSC was also made aware of [staff #13] leaving [client #7] in the bathroom unattended, which is in violation of policy...." The record indicated staff #13 stated, "So sorry, it will not happen again." The report indicated staff #13 will be retrained in regard to client rights and privacy. The report indicated signatures from staff #13, the HM (House Manager) and the SSC.</p> <p>The facility's reportable and investigative</p>			

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	<p>records were reviewed on 11/4/15 at 2:30 PM .The facility records indicated the allegation of neglect/abuse of client #7 by staff #13 recorded in the counseling of 8/28/15 was not reported immediately to the administrator and/or reported to BDDS and/or APS as per state law.</p> <p>During interview with staff #5 on 11/5/15 at 7:30 AM, staff #5 indicated he had reported an incident of a female co-worker having client #7 hold onto the bathroom sink counter top while the female staff that was assigned to client #7 used the restroom herself with client #7 in the room. Staff #5 stated, "That was just wrong. She apparently thought since he was blind it was not a big deal." Staff #5 indicated he heard this from another co-worker and asked the co-worker if it had been reported. The co-worker told staff #5 "Not that they were aware of." Staff #5 indicated he reported it immediately to the SSC upon hearing this.</p> <p>During interview with the SSC on 11/5/15 at 11 AM, the SSC:            ___ Indicated immediately after staff #5 was told of the incident with client #7 involving staff #13, staff #5 reported it to the SSC.            ___ Indicated the allegation of abuse/neglect was not reported to BDDS</p>			

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	<p>or APS.</p> <p>__ Indicated no written verification the administrator was notified immediately of the allegation of abuse/neglect.</p> <p>__ Indicated at the time of the incident she did not look at the incident as neglect or abuse and stated, "I was just so taken back by the whole thing, I didn't even think about abuse or neglect at the time. I guess I should have."</p> <p>During interview with the administrator on 11/4/15 at 2:30, the administrator indicated all allegations of abuse/neglect were to be reported immediately to the administrator and to BDDS and APS as per state law within 24 hours of knowledge of the abuse/neglect.</p> <p>4. The facility's reportable and investigative records were reviewed on 11/4/15 at 2:30 PM. The 9/9/15 BDDS report indicated "On 9/9/15 it was reported and substantiated that [staff #13] transported five residents [clients #1, #2, #5, #6 and #8) to the park on Sunday, September 6, 2015 with no other staff present. This outing was not approved by the House Manager and jeopardized the residents' safety with a staffing ratio of 1:5." The report indicated staff #13's employment with the facility was terminated on 9/10/15 and "All staff that had firsthand knowledge of this incident</p>			

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W 0154 Bldg. 00	<p>or had heard of this incident and did not report it immediately, which McSherr policy requires, received disciplinary action per McSherr's Disciplinary policy and BDDS regulations on incident reporting."</p> <p>During interview with the SSC on 11/5/15 at 11 AM, the SSC:            ___ Indicated two staff were working in the home on 9/6/15.            ___ Indicated there was a ratio of one staff to two clients when going out into the community.            ___ Indicated the facility was responsible to ensure sufficient staffing at all times and lack of supervision was considered neglect.            ___ Indicated the staff working on 9/6/15 failed to report the outing resulting in staff neglect and stated, "All staff aware of the incident should have reported the incident immediately to the administrator."            ___ Indicated the staff are trained to report abuse/neglect immediately to the administrator.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all</p>				

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	<p>alleged violations are thoroughly investigated.</p> <p>Based on observation, interview and record review for 3 of 5 allegations of abuse/neglect reviewed, the facility failed to ensure an investigation was conducted for clients #1, #2, #4, #5, #6, #7 and #8.</p> <p>Findings include:</p> <p>1. The facility's reportable and investigative records were reviewed on 11/4/15 at 2:30 PM. The 8/4/15 BDDS report indicated on 8/3/15 between 7 AM and 7:30 AM, "staff was passing the morning meds. [Client #4] was the last resident to receive her morning meds. As the staff was checking off [client #4's] medicine in the med book she (the staff) realized that she had not only given [client #4] her morning meds but also her evening meds as well. Staff called Mcsherr's HSC (Health Services Coordinator/RN) and reported the med error. According to staff, she (the staff) stated she was very tired and that was the reason she made the med error. HSC went to the group home and spoke with staff and [client #4]. Assessed [client #4]; V/S (vital signs) stable, appeared drowsy but alert. HSC phoned [client #4's NP's] office to report medication error and to get orders. Received the following orders during the same phone call: Watch for</p>	W 0154	<p><b>Name and Address of Provider:</b> McSherr, Inc., 4412 So. B. Street, Richmond, IN</p> <p><b>Date Survey Completed:</b> 12/3/2015</p> <p><b>Provider Identification Number:</b> 15G457</p> <p><b>Survey Event ID:</b> DYHD11</p> <p><b>Finding: W154</b> - The facility failed to ensure an investigation was conducted for clients #1, #2, #4, #5, #6, #7, and #8</p> <p><b>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>· Employees determined to have been guilty of the allegations were terminated from employment with McSherr.</li> <li>· All allegations of neglect and/or abuse, including medication errors, violation of resident rights, injuries of unknown origin, and insufficient staff ratio, will be immediately reported to the administrator, BDDS, and APS per regulations, state law, and McSherr policy and will be <b>investigated</b> per policy and regulations.</li> <li>· All investigations of neglect or abuse, will include a specific plan of corrective oversight that will include how McSherr staff will be monitored to prevent recurrence (this includes adding a 6a-9a</li> </ul>	12/20/2015			

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	<p>sedation and not to give any of her (client #4's) routine medications this evening and resume medications in the morning. [Client #4] was kept home from day programming and placed on standby assistance today. Staff was to keep her in line of sight and if it was noticed that she was going to stand up, staff were to accompany her until she was seated again due to possible dizziness. Staff were also informed to take client #4's V/S (vital signs): BP (blood pressure), P (pulse), O2 (pulse oximeter/oxygen saturation in the blood) sat hourly until 10 PM today."</p> <p>The 8/6/15 Follow Up BDDS report indicated client #4 did not experience any adverse side-effects from the medication error and her vital signs and level of consciousness were monitored for twelve hours following the error. The staff member that made the error was suspended from passing medications until the staff was retrained on basic medication administration.</p> <p>Client #4's record was reviewed on 11/9/15 at 3 PM. Client #4's Medication Administration Records (MARs) for August 2015 indicated on 8/3/15 client #4 was to receive the following medications in the AM: Digoxin 125 mcg (micrograms) for</p>		<p>position so night shift staff do nothave to administer medications when they are tired). ·Staff were retrained on SuspectedAbuse, Neglect, and Exploitation and Incident Reporting on 11/23/15, whichincluded training on the importance of staff ratios and reporting immediatelyif a staff member leaves without express permission from the manager. ·Bi-Monthly house meetings will includesections on Resident Rights as well as Abuse and Neglect and reporting ·SSCquarterly interviews of staff and clients asking if they have any concerns ofsuspected abuse and neglect will now include specific questions relating toresident rights, ensuring dignity, andincident reporting. Questions will nowbe more "open ended" requiring staff and clients to answer in more detailinstead of being able to answer with a yes or no.</p> <p><b>Howwill you identify other residents having the potential to be affected by thesame deficient practice and what corrective action will be taken?</b> All Consumers have the potential to beaffected ·Employeesdetermined to have been guilty of the allegations were terminated fromemployment with McSherr. ·Allallegations of neglect and/or</p>		

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	<p>tachycardia (a fast heart rhythm). Zyrtec 10 mg (milligrams) for allergies. Bisoprolol-HCTZ 2.5-6.25 (half tab) for high blood pressure. Klonopin 0.5 mg (half tab) for behavior control. Cran (Cranberry)-max 500 mg (a dietary supplement). Miralax 17 gm (grams) for constipation. Oys (Oyster) Cal+D 500/200 (a dietary supplement). Oxybutynin 5 mg for an overactive bladder. Fiber-Lax 2 caps (a dietary supplement). Pepcid 20 mg for indigestion.</p> <p>Client #4's MARs for August 2015 indicated on 8/3/15 client #4 was to receive the following medications in the PM: Oxybutynin 5 mg. Oys Cal+D 500/200. Fiber-Lax 2 caps. Pepcid 20 mg. Colace 100 mg for constipation. Seroquel XR 150 mg for behavior control. Haldol 10 mg for behavior control.</p> <p>During interview with the SSC on 11/5/15 at 11 AM, the SSC: __ Stated, "We didn't conduct an official investigation." __ Indicated the RN spoke with the staff</p>		<p>abuse, including medication errors, violation of resident rights, injuries of unknown origin, and insufficient staff ratio, will be immediately reported to the administrator, BDDS, and APS per regulations, state law, and McSherr policy and will be <b>investigated</b> per policy and regulations.</p> <ul style="list-style-type: none"> <li>· All investigations of neglect or abuse, will include a specific plan of corrective oversight that will include how McSherr staff will be monitored to prevent recurrence (this includes adding a 6a-9a position so night shift staff do not have to administer medications when they are tired).</li> <li>· Staff were retrained on Suspected Abuse, Neglect, and Exploitation and Incident Reporting on 11/23/15, which included training on the importance of staff ratios and reporting immediately if a staff member leaves without express permission from the manager.</li> <li>· Bi-Monthly house meetings will include sections on Resident Rights as well as Abuse and Neglect and reporting</li> <li>· SSC quarterly interviews of staff and clients asking if they have any concerns of suspected abuse and neglect will now include specific questions relating to resident rights, ensuring dignity, and incident reporting. Questions will now be more "open ended" requiring staff and clients to answer in more detail instead</li> </ul>				

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	<p>that made the error.</p> <p>__ Indicated at the time of the incident she did not look at the incident as neglect or abuse.</p> <p>__ Stated, "In looking back, due to the severity of the error, I should have done an investigation."</p> <p>2. Observations were conducted at the group home on 11/4/15 between 3:45 PM and 6 PM and on 11/5/15 between 6 AM and 8 AM. Client #7 was a blind, middle aged male who was unsteady on his feet and required staff assistance for ambulation and mobilization to navigate through the home and to use the restroom. During both observation periods, the staff accompanied client #7 in and out of the bathroom and stayed with client #7 while using the restroom.</p> <p>Review of employee #13's records on 11/5/15 at 1 PM indicated a counseling record dated 8/28/15. The record indicated the "SSC has been made aware of a situation where the resident's right to privacy has not always been insured by [staff #13]. It was reported that [staff #13] had [client #7] hold onto the bathroom counter while she used the restroom. This type of activity is inappropriate and violates the policies.... SSC was also made aware of [staff #13] leaving [client #7] in the bathroom</p>		<p>ofbeing able to answer with a yes or no.</p> <ul style="list-style-type: none"> <li>ProfessionalQuarterly Review will include discussion of all investigations. PQR is comprised of QIDP, Social SC, HSC, andResidential Administrator</li> </ul> <p><b>Whatmeasures will be put into place or what systemic changes you will make to ensurethat the deficient practice does not recur?)</b></p> <ul style="list-style-type: none"> <li>Allallegations of neglect and/or abuse, including medication errors, violation ofresident rights, injuries of unknown origin, and insufficient staff ratio, will be immediately reported to theadministrator, BDDS, and APS per regulations, state law, and McSherr policy andwill be <b>investigated</b> per policy andregulations.</li> <li>Allinvestigations of neglect or abuse, will include a specific plan of correctiveoversight that will include how McSherr staff will be monitored to preventrecurrence (this includes adding a 6a-9a position so night shift staff do nothave to administer medications when they are tired).</li> <li>Staff were retrained on SuspectedAbuse, Neglect, and Exploitation and Incident Reporting on 11/23/15, whichincluded training on the importance of staff ratios and reporting immediatelyif a staff member leaves without express permission from the manager.</li> </ul>				

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	<p>unattended, which is in violation of policy...." The record indicated staff #13 stated, "So sorry, it will not happen again." The report indicated staff #13 will be retrained in regard to client rights and privacy. The report indicated signatures from staff #13, the HM (House Manager) and the SSC.</p> <p>The facility's reportable and investigative records were reviewed on 11/4/15 at 2:30 PM. The facility records indicated the allegation of neglect/abuse of client #7 by staff #13 recorded in the counseling of 8/28/15 was not reported immediately to the administrator and/or reported to BDDS and/or APS as per state law. The facility records indicated no investigation was conducted in regard to the allegation of neglect/abuse of client #7 by staff #13.</p> <p>During interview with staff #5 on 11/5/15 at 7:30 AM, staff #5 indicated he had reported an incident of a female co-worker having client #7 hold onto the bathroom sink counter top while the female staff that was assigned to client #7 used the restroom herself with client #7 in the room. Staff #5 stated, "That was just wrong. She apparently thought since he was blind it was not a big deal." Staff #5 indicated he heard this from another co-worker and asked the co-worker if it had been reported. The co-worker told</p>		<p>·Bi-Monthly house meetings will include sections on Resident Rights as well as Abuse and Neglect and reporting</p> <p>·SSC quarterly interviews of staff and clients asking if they have any concerns of suspected abuse and neglect will now include specific questions relating to resident rights, ensuring dignity, and incident reporting. Questions will now be more "open ended" requiring staff and clients to answer in more detail instead of being able to answer with a yes or no.</p> <p>·Professional Quarterly Review will include discussion of all investigations. PQR is comprised of QIDP, Social SC, HSC, and Residential Administrator</p> <p><b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur (quality assurance program, etc.) and how will it be put into place?</b></p> <p>·All investigations of neglect or abuse, will include a specific plan of corrective oversight that will include how McSherr staff will be monitored to prevent recurrence (this includes adding a 6a-9a position so night shift staff do not have to administer meds when they are tired).</p> <p>·Accident &amp; Injury reports are reviewed by Professional</p>	

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	<p>staff #5 "Not that they were aware of." Staff #5 indicated he reported the allegation immediately to the SSC upon hearing this.</p> <p>During interview with the SSC on 11/5/15 at 11 AM, the SSC: __ Indicated staff #5 reported the incident of staff #13 using the restroom in front of and while supervising client #7. __ Indicated at the time of the incident she did not look at it as neglect or abuse and stated, "I was just so taken back by the whole thing, I didn't even think about abuse or neglect at the time. I guess I should have." __ Indicated no investigation was conducted in regard to the abuse/neglect of client #7 and the client's personal privacy and client rights.</p> <p>3. The facility's reportable and investigative records were reviewed on 11/4/15 at 2:30 PM. The 9/9/15 BDDS report indicated "On 9/9/15 it was reported and substantiated that [staff #13] transported five residents [clients #1, #2, #5, #6 and #8) to the park on Sunday, September 6, 2015 with no other staff present. This outing was not approved by the House Manager and jeopardized the residents' safety with a staffing ratio of 1:5." The report indicated staff #13's employment with the facility was</p>		<p>Quarterly Review to determine if an investigation should have been done.</p> <p>· Professional Quarterly Review will include discussion of all investigations. PQR is comprised of QIDP, Social Services Coordinator, Health Services Coordinator, and Residential Administrator</p> <p>· SSC quarterly interviews of staff and clients asking if they have any concerns of suspected abuse and neglect will now include specific questions relating to resident rights and incident reporting. Questions will now be more "open ended" requiring staff and clients to answer in more detail instead of being able to answer with a yes or no. Reports will be reviewed monthly at IDT</p> <p><b>What is the date by which the systemic changes will be completed? 12/20/15</b></p> <p><b>Respectfully Submitted, Rosemary Taylor, Residential Administrator</b></p>		

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	<p>terminated on 9/10/15 and "All staff that had firsthand knowledge of this incident or had heard of this incident and did not report it immediately, which McSherr policy requires, received disciplinary action per McSherr's Disciplinary policy and BDDS regulations on incident reporting."</p> <p>The facility investigative records indicated no investigation in regard to the allegation of neglect to ensure sufficient staff supervision for clients #1, #2, #5, #6 and #8 on 9/6/15 when taken out into the community.</p> <p>During interview with the SSC on 11/5/15 at 11 AM, the SSC:            ___ Indicated two staff were working in the home on 9/6/15.            ___ Indicated there was a ratio of one staff to two clients when going out into the community.            ___ Indicated the staff failed to provide sufficient staffing and supervision for clients #1, #2, #5, #6 and #8 on 9/6/15.            ___ Indicated the staff working that day failed to report the outing and all staff aware of the incident should have reported it immediately.            ___ Indicated no investigation in regard to the allegation of staff neglect to ensure sufficient staffing while taking the clients out into the community.</p>			

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W 0227 Bldg. 00	<p>9-3-2(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on interview and record review for 2 of 4 sampled clients (#1 and #2), the clients' Individual Support Plans (ISPs) failed to address the clients' identified training need in regard to pedestrian safety skills.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 11/9/15 at 11 AM. The record indicated client #1 was admitted to the facility on 8/17/15.</p> <p>Client #1's record indicated an "Elopement High Risk Plan" dated 8/17/15. The plan indicated "Prior to moving into the [name of street] group home [client #1] lived in the community on his own and had unlimited access to the community. There is the possibility that [client #1] could attempt to leave the group home based on this prior</p>	W 0227	<p><b>Name and Address of Provider:</b> McSherr, Inc., 4412 So. B. Street, Richmond, IN</p> <p><b>Date Survey Completed:</b> 12/3/15</p> <p><b>Provider Identification Number:</b> 15G457</p> <p><b>Survey Event ID:</b> DYHD11</p> <p><b>Finding: W227</b>– the client's Individual Support Plan (ISP) failed to address the client #1 and #2's identified training need in regard to pedestrian safety skills</p> <p><b>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice?</b> ·Clients #1 and #2 Individual Support Plan will include Pedestrian Safety Skills</p> <p><b>How will you identify other residents having the potential to be affected by the same</b></p>	12/20/2015	

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	<p>experience." The plan indicated staff would be assigned to accompany client #1 on all community outings and would educate client #1 on the importance of not leaving the home unless accompanied by staff.</p> <p>Client #1's Functional Assessment Report (FAR) dated 9/10/15 indicated client #1 "does need verbal cues to be safe on streets" and required verbal assistance with pedestrian safety skills.</p> <p>Client #1's ISP dated 9/10/15 indicated no training objectives to assist client #1 with pedestrian safety skills.</p> <p>Interview with the QIDP on 11/13/15 at 3:45 PM indicated client #1's ISP did not include any training objectives in regard to pedestrian safety.</p> <p>2. Client #2's record was reviewed on 11/9/15 at 12 PM. The record indicated client #2 was admitted to the facility on 7/20/15.</p> <p>Client #2's record indicated an "Elopement High Risk Plan" dated 7/20/15. The plan indicated "Prior to moving into the [name of street] group home [client #2] lived in the community on his own and had unlimited access to the community. There is the possibility</p>		<p><b>deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>·Allconsumers have the potential to be affected.</li> <li>·All consumer Comprehensive Assessmentswill be reviewed to determine if others need Pedestrian Safety Skills</li> <li>·Pedestrian Safety Skills will beincluded in the ISP for those who need it</li> </ul> <p><b>Whatmeasures will be put into place or what systemic changes you will make toensure that the deficient practice does not recur?)</b></p> <ul style="list-style-type: none"> <li>·IDT will add a section for PedestrianSafety Skills to determine if anyone has a need</li> <li>·Pedestrian Safety Skill needs will bereviewed at least annually or more often if changes are noted</li> </ul> <p><b>Howwill the corrective action(s) be monitored to ensure the deficient practicewill not recur (quality assurance program, etc.) and how will it be put intoplace?</b></p> <ul style="list-style-type: none"> <li>·SocialServices Coordinator, Health Services Coordinator, QIDP, and ResidentialAdministrator will review for need on a monthly basis at IDT</li> <li>·ProfessionalQuality Review will review on a quarterly basis</li> </ul>	

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W 0252 Bldg. 00	<p>that [client #2] could attempt to leave the group home based on this prior experience." The plan indicated staff would be assigned to accompany client #2 on all community outings and would educate client #2 on the importance of not leaving the home unless accompanied by staff.</p> <p>Client #2's FAR dated 8/18/15 indicated client #2 required verbal assistance with pedestrian safety.</p> <p>Client #2's ISP dated 8/18/15 indicated no training objectives to assist client #2 with pedestrian safety skills.</p> <p>Interview with the QIDP on 11/13/15 at 3:45 PM indicated client #2's ISP did not include any training objectives in regard to pedestrian safety.</p> <p>9-3-4(a)</p> <p>483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. Based on record review and interview for 2 of 4 sample clients (#1 and #3), the facility failed to ensure the staff</p>	W 0252	<p><b>What is the date by which the systemic changes will be completed?</b> 12/20/15</p> <p><b>Respectfully Submitted,</b> <b>Rosemary Taylor, Residential Administrator</b></p> <p><b>Name and Address of Provider:</b> McSherr, Inc., 4412 So. B. Street, Richmond, IN <b>Date Survey Completed:</b></p>	12/20/2015

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	<p>documented the results of all PRN (as needed) medications given to clients #1 and #3.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 11/9/15 at 11 AM.</p> <p>Client #1's 2015 physician's orders indicated:            __ Tylenol 325 mg (milligrams) tablets take two tablets every four hours PRN (as needed) for pain.            __ Robitussin Syrup take 10 ml (milliliters) every four hours PRN for cough.</p> <p>Client #1's 2015 MARs indicated:            __ The staff gave client #1 a PRN dose of Robitussin for a cough on the following dates: September 29, 30, October 1, 2, 3, 10, 12, 15, 16, 17, 18, 19, 22, 23, 25, 26, 27, 28, 30, 31, November 6, 7 and 8, 2015.            __ The staff gave client #1 a PRN dose of Tylenol for pain on the following dates: August 26, 27, September 5, 13, 16, 21, 22, October 25, 27, November 3 and 5, 2015</p> <p>Client #1's MARs indicated the following documentation for results of the PRNs given:</p>		<p>12/3/15</p> <p><b>Provider Identification Number:</b> 15G457</p> <p><b>Survey Event ID:</b> DYHD11</p> <p><b>Finding: W252-</b> the facility failed to ensure the staff documented the results of all PRN medications given to clients #1 and #3</p> <p><b>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice?</b>            · Staff will document on Clients #1 and Client #3 as to effectiveness and how they are feeling when given a PRN</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b>            All consumers have the potential to be affected.            · Staff will document on all clients as to effectiveness and how they are feeling after being given a PRN medication.</p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b>            · A form has been developed that will be attached to the MAR that will document how the client</p>		

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	<p>08/26/15 - No documented results of the PRN given.</p> <p>08/27/15 - No documented results of the PRN given.</p> <p>09/05/15 for ankle pain - No documented results of the PRN given.</p> <p>09/16/15 for a headache - No documented results of the PRN given.</p> <p>09/21/15 for a headache - No documented results of the PRN given.</p> <p>09/22/15 for a headache - No documented results of the PRN given.</p> <p>09/29/15 - No documented results of the PRN given.</p> <p>09/30/15 - No documented results of the PRN given.</p> <p>10/01/15 - "went to bed" - No documented results of the PRN given.</p> <p>10/02/15 - No documented results of the PRN given.</p> <p>10/03/15 - No documented results of the PRN given.</p> <p>10/10/15 - No documented results of the PRN given.</p> <p>10/12/15 - No documented results of the PRN given.</p> <p>10/15/15 - "Thanked me (the staff), went to room." No documented results of the PRN given.</p> <p>10/16/15 - No documented results of the PRN given.</p> <p>10/17/15 - No documented results of the PRN given.</p> <p>10/18/15 - "Got ready for bed." No</p>		<p>is feeling after being given a PRN.</p> <ul style="list-style-type: none"> <li>The result of the PRN will be documented in Professional Nursing Notes weekly as well as on the MAR</li> <li>HSC will review and sign off on PRN sheets on a weekly basis.</li> </ul> <p><b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur (quality assurance program, etc.) and how will it be put into place?</b></p> <ul style="list-style-type: none"> <li>HSC will monitor through weekly review</li> </ul> <p><b>What is the date by which the systemic changes will be completed?</b> 12/20/15</p> <p><b>Respectfully Submitted,</b> <b>Rosemary Taylor, Residential Administrator</b></p>	

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	<p>documented results of the PRN given.</p> <p>10/19/15 - "Got ready for workshop." No documented results of the PRN given.</p> <p>10/22/15 - No documented results of the PRN given.</p> <p>10/23/15 - No documented results of the PRN given.</p> <p>10/25/15 - No documented results of the PRN given.</p> <p>10/26/15 - No documented results of the PRN given.</p> <p>10/27/15 - "Workshop." No documented results of the PRN given.</p> <p>10/28/15 - "Workshop." No documented results of the PRN given.</p> <p>10/30/15 - No documented results of the PRN given.</p> <p>10/31/15 - "better."</p> <p>11/03/15 - No documented results of the PRN given.</p> <p>11/05/15 - No documented results of the PRN given.</p> <p>11/06/15 - No documented results of the PRN given.</p> <p>11/07/15 - No documented results of the PRN given.</p> <p>11/08/15 - No documented results of the PRN given.</p> <p>Client #1's 2015 MARs indicated the staff failed to document the effects and/or results of the PRNs given.</p> <p>Client #3's record was reviewed on</p>			

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	<p>11/9/15 at 2 PM.</p> <p>Client #3's 2015 physician's orders indicated:            __ Tylenol 325 mg (milligrams) tablets take two tablets every four hours PRN for pain.            __ Sweet Oil 3 drops into each ear at bedtime for wax buildup.            __ MOM (Milk of Magnesia) 30 cc (cubic centimeter) at bedtime as needed for constipation.</p> <p>Client #3's 2015 MARs indicated:            __ The staff gave client #3 a PRN dose of Tylenol for pain on the following dates: August 26, 27, September 5, 9, 10, 15, 20, 24, October 6, 18, 29, 31, November 1, 3, 4, 6 and 8, 2015.            __ The staff gave client #3 a PRN dose of MOM for constipation on September 29, October 20, 27, November 11, 2015.            __ The staff gave client #3 a PRN dose of Sweet Oil in each ear for wax buildup on September 21 and 25.</p> <p>Client #3's MARs indicated the following documentation for results of the PRNs given:            09/05/15 for foot pain - No documented results of the PRN given.            09/09/15 - No documented results of the PRN given.            09/10/15 for general discomfort - No</p>			

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	<p>documented results of the PRN given. 09/15/15 for a headache - No documented results of the PRN given. 09/20/15 for a headache - No documented results of the PRN given. 09/21/15 - No documented results of the PRN given. 09/24/15 (given twice) - for foot pain - No documented results of either PRN given. 09/25/15 - No documented results of the PRN given. 09/29/15 - No documented results of the PRN given. 10/06/15 - "for a headache" - No documented results of the PRN given. 10/18/15 - "for a headache" - No documented results of the PRN given. 10/20/15 - "went to bed" - No documented results of the PRN given. 10/27/15 - "went to watch TV (television) No documented results of the PRN given. 10/29/15 "for hip and leg pain - "lying down" - No documented results of the PRN given. 10/31/15 "for headache" - No documented results of the PRN given. 11/01/15 "for backache" - No documented results of the PRN given. 11/03/15 "for backache" - No documented results of the PRN given. 11/04/15 "for backache and headache" - No documented results of the PRN given.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G457	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2015
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NAME OF PROVIDER OR SUPPLIER  MCSHERR INC - B ST	STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374
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W 0263 Bldg. 00	<p>11/06/15 - No documented results of the PRN given.</p> <p>11/08/15 "for back pain" - No documented results of the PRN given.</p> <p>11/11/15 "for constipation" - No documented results of the PRN given.</p> <p>Client #3's 2015 MARs indicated the staff failed to document the effects and/or results of the PRNs given.</p> <p>During email interview with the RN and the Administrator on 11/13/15 at 5:18 PM, the administrator indicated whenever a client was given a PRN medication, the staff were to do an assessment of the response to the PRN for effectiveness and results were to be documented on the back of the clients' MARs beside the documentation of the PRN being given.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(ii) PROGRAM MONITORING &amp; CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on interview and record review for 1 of 4 sampled clients (#1), the facility failed to obtain written informed consent from the</p>	W 0263	<p><b>Name and Address of Provider:</b> McSherr, Inc., 4412 So. B. Street, Richmond, IN <b>Date Survey</b></p>	12/20/2015

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	<p>client's guardian for the client's restrictive program.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 11/9/15 at 11 AM.</p> <p>Client #1's Behavior Support Plan (BSP) dated 8/17/15 indicated client #1 had targeted behaviors of non-compliance and verbal aggression and was at risk of elopement. Client #1's BSP indicated client #1 received Cymbalta 60 milligrams a day for depression.</p> <p>Client #1's 9/10/15 Individual Support Plan (ISP) indicated client #1's sister served as client #1's legal guardian. Client #1's record indicated the facility had not obtained written informed consent from client #1's legal representative for the client's restrictive BSP.</p> <p>During interview with the Qualified Intellectual Disabilities Professional (QIDP) on 11/9/15 at 1 PM, the QIDP indicated she had not obtained written informed consent from client #1's legal guardian for the client's restrictive program plan.</p> <p>9-3-4(a)</p>		<p><b>Completed: 12/3/15</b></p> <p><b>ProviderIdentification Number: 15G457 SurveyEvent ID:DYHD11 Finding: W263</b>– the facility failed to obtain written informed consent from the client #1's guardian for the client's restrictive program</p> <p><b>Whatcorrective action(s) will be accomplished for these residents found to havebeen affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>·Client #1 received a waiver and hasmoved to a waiver site with another provider not allowing McSherr to correctthe error with Client #1</li> <li>·McSherr policy requires QIDP to obtainwritten informed consent from guardian for restrictive program plans but QIDPfailed to do so.</li> </ul> <p><b>Howwill you identify other residents having the potential to be affected by thesame deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>·Allconsumers with a restrictive program and guardian have the potential to beaffected.</li> <li>·WrittenInformed Consent from guardians will be obtained for restrictive program plansin the future.</li> <li>·Requestswill be emailed to guardians for those that have email capabilities. Other guardians will receive the documentsvia U.S. mail.</li> <li>·IDT will monitor the above</li> </ul>		

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W 0331  Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and	W 0331	<p>monthly</p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>·Written informed consent from guardians will be obtained for restrictive programs plans in the future</li> <li>·Requests will be emailed to guardians for those that have email capabilities. Other family guardians will receive the documents via U.S. mail.</li> <li>·IDT will monitor the above monthly</li> </ul> <p><b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur (quality assurance program, etc.) and how will it be put into place?</b></p> <ul style="list-style-type: none"> <li>·QIDP will include with monthly IDT report status of required guardian approvals.</li> <li>·Residential Administrator will monitor</li> <li>·Monthly IDT will monitor</li> </ul> <p><b>What is the date by which the systemic changes will be completed?</b> 12/20/15</p> <p><b>Respectfully Submitted,</b> <b>Rosemary Taylor, Residential Administrator</b></p> <p><b>Name and Address of</b></p>	12/20/2015	

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	<p>interview for 2 of 4 sample clients (#1 and #2), the facility nursing services failed to ensure:</p> <p>__ Client #1's physician's orders were followed in regard to the client's blood sugar tests.</p> <p>__ The recommendations of NAS (No Added Salt) were added to client #2's physician's order.</p> <p>Findings include:</p> <p>1. Observations were conducted at the group home on 11/5/15 between 6 AM and 8 AM.</p> <p>__ At 6:35 AM client #1 stood at the kitchen counter and ate two slices of toast with peanut butter and drank a cup of coffee.</p> <p>__ At 7:15 AM staff #3 tested client #1's BS with a glucometer and obtained a result of 160.</p> <p>Review of client #1's November 2015 MAR (Medication Administration Record) on 11/5/15 at 7:30 AM indicated client #1's BS had not been tested on November 1, 2, 3 and 4, 2015.</p> <p>Client #1's record was reviewed on 11/9/15 at 11 AM.</p> <p>__ Client #1's record indicated client #1 was admitted to the facility on 8/17/15.</p> <p>__ Client #1's admission physician's</p>		<p><b>Provider:</b> McSherr, Inc., 4412 So. B. Street, Richmond, IN</p> <p><b>Date Survey Completed:</b> 12/3/15</p> <p><b>Provider Identification Number:</b> 15G457</p> <p><b>Survey Event ID:</b> DYHD11</p> <p><b>Finding:</b> W331– the facility nursing services failed to:</p> <ul style="list-style-type: none"> <li>·Ensure Client#1’s physician orders were followed in regard to the client’s blood sugar tests</li> <li>·Ensure therecommendations of NAS were added to client #2’s physician orders</li> </ul> <p><b>What corrective action(s) will be accomplished for these residents found to have been affected by this finding?</b></p> <ul style="list-style-type: none"> <li>·Health Services Coordinator (HSC) failed to monitor blood sugar test every other day for client #1. Client #1 has moved to a waiver program so a correction cannot be made for him.</li> <li>·Health Services Coordinator has contacted Dr. Edmiston, Client #2’s physician and NAS has been added to his physician orders.</li> </ul> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <p>All consumers with diabetes and NAS recommendations have the</p>	

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	<p>orders dated 8/17/15 indicated "Check blood sugars fasting (prior to eating) every other day."</p> <p>During interview with staff #3 on 11/5/15 at 7:20 AM, staff #3:            ___ Indicated client #1 was to have his BS tested qod (every other day).            ___ Indicated client #1's November MAR did not include the testing of client #1's BS qod.            ___ Indicated client #1's blood sugars were not always tested prior to client #1 eating his breakfast and stated, "Most of the time he (client #1) has us check it (client #1's BS) after he's ate his breakfast."            ___ Stated, "It does make more sense that we (the staff) test his (client #1's) BS before he eats compared to after."</p> <p>During interview with client #1 on 11/5/15 at 7:25 AM, client #1 stated the staff had not tested his blood sugar for "several days" and the staff "usually" tested client #1's BS after client #1 ate his breakfast.</p> <p>During interview with the RN on 11/5/15 at 7:30 AM, the RN:            ___ Stated, "The pharmacy must have left the BS testing off the November MAR."            ___ Stated "I must have missed the BS testing when the November MARs were distributed to the group home."</p>		<p>potential to be affected</p> <ul style="list-style-type: none"> <li>·HealthServices Coordinator will monitor MAR's for blood sugar draws on a weekly basisand will sign upon review</li> <li>·HealthServices Coordinator will review all dietary/nutritional recommendationsquarterly to ensure compliance and will sign that review has been completed</li> <li>·HouseManager will include any new dietary recommendations on Physician Appointmentform to take to PCP on 90 day recerts and Annuals</li> <li>·Staffwill be trained on any new dietary recommendations</li> </ul> <p><b>Whatmeasures will be put into place or what systemic changes you will make toensure that the deficient practice does not recur?)</b></p> <ul style="list-style-type: none"> <li>·HealthServices Coordinator will monitor MAR's for blood sugar draws on a weekly basisand will sign upon review</li> <li>·HouseManager will review MARS for compliance at the end of each month and reportdiscrepancies to Administrator</li> <li>·HealthServices Coordinator will review all dietary/nutritional recommendationsquarterly to ensure compliance and will sign that review has been completed</li> <li>·HSCwill update PCP on dietary recommendations as deemed necessary by dietician</li> <li>·HouseManager will include any new dietary recommendations on</li> </ul>	

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W 0368  Bldg. 00	<p>___ Indicated the staff should have questioned it not being on the MAR and should have called the RN. ___ Stated, "I'll add it to his (client #1's) MAR now."</p> <p>2. Client #2's record was reviewed on 11/9/15 at 12 PM. Client #2's Nutritional Assessments indicated: ___ 8/11/15 from the dietician indicated "Do feel it is appropriate to consider a NAS (No Added Salt) diet as well." ___ 11/10/15 recommended again NAS be added to client #2's physician's orders.</p> <p>Client #2's 10/19/15 physician's orders indicated client #2 was to have an 1800 calorie diet. Client #2's physician's orders did not include an order for NAS.</p> <p>During email interview with the RN and the Administrator on 11/12/15 at 2:16 PM, the RN indicated no response when asked if NAS had been added to client #2's physician's orders.</p> <p>9-3-6(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in</p>		<p>Physician Appointmentform to take to PCP on 90 day recerts and Annuals ·Staffwill be trained on new dietary recommendations.</p> <p><b>Howwill the corrective action(s) be monitored to ensure the deficient practicewill not recur (quality assurance program, etc.) and how will it be put into place?</b> ·HSCwill monitor blood sugar draws and quarterly dietary assessments ·ProfessionalQuarterly Review will review Dietary Recommendations for compliance andphysician notification ·HouseManager will monitor MARS and dietary recommendations and report discrepanciesto Administrator</p> <p><b>Whatis the date by which the systemic changes will be completed?</b> 12/20/15</p> <p><b>RespectfullySubmitted, RosemaryTaylor, Residential Administrator</b></p>		

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	<p>compliance with the physician's orders. Based on record review and interview for 1 of 4 sampled clients (#4) and 3 additional clients (#5, #7 and #8), the facility failed to ensure all drugs were administered to the clients in compliance with the clients' physician's orders.</p> <p>Findings include:</p> <p>The facility's reportable records were reviewed on 11/4/15 at 12 PM.</p> <p>The 1/24/15 Bureau of Developmental Disabilities Services (BDDS) report indicated client #7 did not receive his Metformin (a diabetic medication) on the morning of 01/23/15. The report indicated the pill was still in the medication packet and the buddy checker (a staff that checks the medications were given without error) did not find the error immediately after the medication was passed.</p> <p>The 4/10/15 BDDS report indicated on 4/9/15 client #4 did not receive her morning medications of Vitamin D and Ditropan (for bladder problems). The report indicated "It was reported to the RN that the MARs (Medication Administration Records) had been initialed indicating these medications were given and the buddy checked had</p>	W 0368	<p><b>Name and Address of Provider:</b> McSherr, Inc., 4412 So. B. Street, Richmond, IN</p> <p><b>Date Survey Completed:</b> 12/3/15</p> <p><b>Provider Identification Number:</b> 15G457</p> <p><b>Survey Event ID:</b> DYHD11</p> <p><b>Finding: W368</b>— the facility failed to ensure all drugs were administered to clients #4, #5, #7, and #8 in compliance with the clients' physician orders.</p> <p><b>What corrective action(s) will be accomplished for these residents found to have been affected by this finding?</b></p> <ul style="list-style-type: none"> <li>· McSherr South B staff were retrained to administer medication in compliance with clients' physician orders</li> <li>· McSherr added a morning position from 6a-9a so night shift employees do not have to pass meds in the morning after working all night when they might be overly tired (it has been noted that most med errors were occurring during the morning med pass)</li> <li>· Staff at South B will be retrained on the Buddy Check System and responsibility of signing that meds were administered correctly</li> <li>· A more private/secluded med pass area will be designed at</li> </ul>	12/20/2015			

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	<p>been documented as well."</p> <p>The 4/22/15 BDDS report indicated client #4 was given her PM dose of Cranberry 500 mg (milligrams) in the AM in error.</p> <p>The 5/7/15 BDDS report indicated on 5/6/15 client #8 did not receive his AM dose of Flomax (to treat problems with urination) 0.4 mg.</p> <p>The 6/15/15 BDDS report indicated "On Saturday, 6/13/15, staff checked [client #5's] BP (blood pressure) at 4 PM and it was 109/64 when he (client #5) was sitting and 104/62 when he was standing. According to the instructions, if the systolic (the top number of the blood pressure) is less than 110, McSherr HSC (Health Services Coordinator/RN) is to be called and he (the RN) will determine whether the Atenolol (for high blood pressure) should be held at 4 PM. However, on the 13th of June when [client #5's] systolic was less than 110, the staff did not call McSherr's HSC and went ahead and administered the 100 mg of Atenolol."</p> <p>The 6/20/15 BDDS report indicated client #5 did not receive his weekly AM dose of Fosamax (for osteoporosis - weak bones) on 6/19/15 as scheduled.</p>		<p>South B that allows fora more quiet, efficient med pass. <b>Howwill you identify other residents having the potential to be affected by thesame deficient practice and what corrective action will be taken?</b></p> <p>All consumers at South B that havemedications administered have the potential to be affected</p> <ul style="list-style-type: none"> <li>·McSherrSouth B staff were retrained to administer medication in compliance withclients' physician orders</li> <li>·McSherradded a morning position from 6a-9a so night shift employees do not have topass meds in the morning after working all night when they might be overlytired (it has been noted that most med errors were occurring during the morningmed pass)</li> <li>·Staffat South B will be retrained on the Buddy Check System and responsibility ofsigning that meds were administered correctly</li> <li>·Amore private/secluded med pass area will be designed at South B that allows fora more quiet, efficient med pass.</li> </ul> <p><b>Whatmeasures will be put into place or what systemic changes you will make toensure that the deficient practice does not recur?)</b></p> <ul style="list-style-type: none"> <li>·McSherrSouth B staff were retrained to administer medication in compliance</li> </ul>		

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	<p>The 8/4/15 BDDS report indicated "On 8/13/15 at 7 AM - 7:30 AM, staff was passing the morning meds. [Client #4] was the last resident to receive her morning meds. As the staff was checking off [client #4's] medicine in the med book she (the staff) realized that she had not only given [client #4] her morning meds but also her evening meds as well. Staff called Mcsherr's HSC and reported the med error. According to staff, she (the staff) stated she was very tired and that was the reason she made the med error. HSC went to the group home and spoke with staff and [client #4]. Assessed [client #4]; V/S (vital signs) stable, appeared drowsy but alert. HSC phoned [client #4's NP's] office to report medication error and to get orders. Received the following orders during the same phone call: Watch for sedation and not to give any of her (client #4's) routine medications this evening and resume medications in the morning."</p> <p>The 10/8/15 BDDS report indicated on the morning of 10/7/15 the Team Lead (TL) took client #4 to have blood drawn. Once the blood was drawn, the TL and client #4 went out to eat for breakfast. The TL gave client #4 her AM medications. The report indicated "However, [client #4] was started on</p>		<p>withclients' physician orders ·McSherradded a morning position from 6a-9a so night shift employees do not have topass meds in the morning after working all night when they might be overlytired (it has been noted that most med errors were occurring during the morningmed pass) ·Staffat South B will be retrained on the Buddy Check System and responsibility ofsigning that meds were administered correctly ·Amore private/secluded med pass area will be designed at South B that allows fora more quiet, efficient med pass.</p> <p><b>Howwill the corrective action(s) be monitored to ensure the deficient practicewill not recur (quality assurance program, etc.) and how will it be put into place?</b> ·Medicationerrors will be monitored by the IDT on a monthly basis ·HealthServices Coordinator will complete monthly med administration reviews with thestaff at South B for a 6-month period ·HouseManager or designee will observe med pass once per month</p> <p><b>What is the date by which the</b></p>		

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W 0436 Bldg. 00	<p>Cipro (an antibiotic) 500 mg BID (twice a day) for seven days on October 3rd and this med was in a separate bubble card from all of her (client #4's) other meds. Therefore, the Lead DSP (Direct Support Professional) forgot about the Cipro when he picked up her other meds, so [client #4] did not receive her morning dose of Cipro on 10/7/15."</p> <p>During interview with the HSC/RN on 11/13/15 at 3 PM, the HSC indicated all medications were to be given as ordered by the clients' physicians without error.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT 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. Based on observation, interview and record review for 1 of 4 sampled clients (#2) with adaptive equipment, the facility failed to ensure the client was provided a scoop plate or plate guard while dining and to address the recommendations of the Occupational Therapist for bed rails to assist with transfers.</p>	W 0436	<p><b>systemic changes will be completed?</b> 12/20/15</p> <p><b>RespectfullySubmitted, RosemaryTaylor, Residential Administrator</b></p> <p><b>Name and Address of Provider:</b> McSherr, Inc., 4412 So. B. Street,Richmond, IN</p> <p><b>DateSurvey Completed:</b> 12/3/15 <b>ProviderIdentification Number:</b> 15G457</p>	12/20/2015			

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NAME OF PROVIDER OR SUPPLIER  MCSHERR INC - B ST				STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374			
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	<p>Findings include:</p> <p>Observations were conducted at the group home on 11/4/15 between 3:45 PM and 6 PM.</p> <p>__ Client #2 was served Spanish rice, cooked broccoli, a tossed salad, bread sticks and sliced canned pears for his evening meal. Client #2 placed a serving of each food onto his plate and began eating. While trying to scoop the food onto his utensils, client #2 spilled food onto the table. Client #2 was not offered a plate guard and/or a scoop plate to assist in less food spillage.</p> <p>__ Client #2 was a tall thin male who ambulated with an unsteady gait. Client #2's bed did not have bed rails.</p> <p>Client #2's record was reviewed on 11/9/15 at 12 PM.</p> <p>Client #2's Nutritional Review from the Registered Dietician (RD) dated 8/11/15 indicated "He [client #2] reports it was suggested he try a plate guard at meals. This RD questioned if his food sometimes came off of the plate when he was eating and he reported that it did. RD concurred that a plate guard or scoop plate might be beneficial for him and encouraged him to attempt and see which he felt was better and that he preferred....</p>				<p><b>SurveyEvent ID:</b> DYHD11</p> <p><b>Finding: W436</b>– the facility failed to ensure the client was provided a scoop plate or plate guard while dining and to address therecommendations of the Occupational therapist for bed rails to assist withtransfers</p> <p><b>Whatcorrective action(s) will be accomplished for these residents found to havebeen affected by this finding?</b></p> <ul style="list-style-type: none"> <li>·Ascoop plate and plate guard will be offered to Client #2 at mealtime</li> <li>·Client#2 will be assessed again for bed rail need. Client #2 has had no falls out of his bed onto the floor since moving into South B group home. He jumped up onenight to confront his roommate and bumped his ear on his dresser and fallback. He has not proven to be a risk forfalling out of his bed. McSherr will getanother assessment and will offer bedrails to client #2 at bedtime ifassessment requires such..</li> </ul> <p><b>How will you identify other residents havingthe potential to be affected by the same deficient practice and what correctiveaction will be taken?</b></p> <p>All consumers atSouth B with difficulty keeping food on their plate or who are at risk forfalling out of bed have the potential to be affected</p> <ul style="list-style-type: none"> <li>·Adaptivedining equipment or</li> </ul>		

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	<p>10/14 review of notes from OT (Occupational Therapy) and recs (recommendations) for scoop plate made at that time. No further adaptive equipment recommended. After observing snack meal and discussion with consumer, this RD would concur that scoop plate or plate guard could be helpful with him."</p> <p>Client #2's Nutritional Review dated 11/10/15 indicated "Previous note that he (client #2) may try plate guard but he reports he did not want to use it." The RD indicated adaptive devices recommended "trial of scoop plate or plate guard."</p> <p>Client #2's Interdisciplinary Team note dated 9/17/15 indicated on 9/4/15 the Qualified Intellectual Disabilities Professional (QIDP) observed client #2 eating a meal and "two times he (client #2) verbalized to QIDP that he would not use plate guard to help him scoop his food."</p> <p>Client #2's dining plan dated 9/10/15 indicated client #2 was to use a scoop dish.</p> <p>Client #2's Physical Therapy Evaluation dated 7/24/15 indicated client #2 "may benefit from bed rails to assist with decrease of falls with transfers."</p>		<p>bedrails recommended through assessment will be providedfor and offered to Clients needing such</p> <p><b>Whatmeasures will be put into place or what systemic changes you will make toensure that the deficient practice does not recur?)</b></p> <ul style="list-style-type: none"> <li>·Adaptivedining equipment or bedrails recommended through assessment will be providedfor and offered to Clients needing such</li> <li>·Assessmentof need will be discussed at monthly IDT</li> </ul> <p><b>Howwill the corrective action(s) be monitored to ensure the deficient practicewill not recur (quality assurance program, etc.) and how will it be put intoplace?</b></p> <ul style="list-style-type: none"> <li>·AdaptiveEquipment recommendations will be monitored by the IDT on a monthly basis</li> <li>·HouseManager will review and report at IDT if adaptive equipment is offered and used</li> </ul> <p><b>Whatis the date by which the systemic changes will be completed? 12/20/15</b></p> <p><b>RespectfullySubmitted, RosemaryTaylor, Residential Administrator</b></p>	

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W 0484 Bldg. 00	<p>During email interview with the QIDP on 11/12/2015 at 4:56 PM, the QIDP,            ___ Indicated client #2 was offered a plate guard for one meal and the client refused.            ___ Indicated the staff had not attempted again to have client #2 try the plate guard.            ___ Indicated client #2 had not been offered a scoop plate/dish to try to decrease food spillage.            ___ Indicated the recommendation from the OT assessment for the use of bed rails for client #2 had not been addressed.</p> <p>9-3-7(a)</p> <p>483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client. Based on observation and interview for 3 of 4 sampled clients (#1, #2 and #3) and 3 additional clients (#5, #6 and #8), the facility failed to provide the clients with a salad plate and a dessert bowl to prevent the juices from the food from mixing on their plate and to prevent food spillage.</p> <p>Findings include:</p>	W 0484	<p><b>Name and Address of Provider:</b> McSherr, Inc., 4412 So. B. Street, Richmond, IN</p> <p><b>Date Survey Completed:</b> 12/3/15  <b>Provider Identification Number:</b> 15G457  <b>Survey Event ID:</b> DYHD11  <b>Finding:</b> W484– the facility failed to provide the clients with asalad</p>	12/20/2015

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	<p>Observations were conducted at the group home on 11/4/15 between 3:45 PM and 6 PM. Clients #1, #2, #3, #5, #6 and #8 were observed eating their evening meal of Spanish rice, cooked broccoli, a tossed salad, bread sticks and sliced canned pears. The clients were provided a 10 inch dinner plate for their meal. Each of the clients took a serving of each item and placed it on their plate. The juice from the canned pears mixed with all the food on the clients' plates. The staff did prompt the clients to use separate dish or bowl for their salad and/or fruit.</p> <p>During interview with the Qualified Intellectual Disabilities Professional (QIDP) on 11/10/15 at 2 PM, the QIDP:          ___ Indicated the dietician had recommended the facility use the smaller 10 inch dinner plates to encourage the clients to take smaller portions.          ___ Indicated the staff should have offered the clients a small bowl for their salad and canned fruit to keep the food from mixing and to encourage less spillage.</p> <p>9-3-8(a)</p>		<p>plate and a dessert bowl to prevent the juices from the food from mixing on their plate and to prevent food spillage</p> <p><b>What corrective action(s) will be accomplished for these residents found to have been affected by this finding?</b>          · Clients will be offered a salad plate and dessert bowl for their meals</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b>          All consumers at South B have the potential to be affected          · All clients at South B will be offered a salad plate and dessert bowl for their meals</p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b>          · All clients at South B will be offered a salad plate and dessert bowl for their meals</p> <p><b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur (quality assurance program, etc.) and how will it be put into place?</b>          · House Manager will monitor</p>				

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			<p>during mealtime observations to ensure clients are offered salad lates and dessert bowls</p> <p>·RA,SSC, HSC, and QIDP will monitor when in the house during mealtime</p> <p><b>What is the date by which the systemic changes will be completed? 12/20/15</b></p> <p><b>Respectfully Submitted, Rosemary Taylor, Residential Administrator</b></p>		