

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G579	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/10/2013
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NAME OF PROVIDER OR SUPPLIER MCSHERR INC - NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 496 DENNY DR NEW CASTLE, IN 47362
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W000000	<p>This visit was for a post certification revisit (PCR) to the extended annual recertification and state licensure survey completed on 7/29/13.</p> <p>Dates of Survey: September 9 and 10, 2013.</p> <p>Provider Number: 15G579 Facility Number: 001093 AIM Number: 100239970</p> <p>Surveyor: Vickie Kolb, RN</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 9/30/13 by Ruth Shackelford, QIDP.</p>	W000000		

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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W000210	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on observation, record review and interview for 1 additional client (#6), the facility failed to ensure the Interdisciplinary Team (IDT) re-assessed client #6 in regard to his mobility needs.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 9/9/13 between 3:45 PM and 6:45 PM. Client #6 sat in a wheel chair until time for the evening meal. At 6 PM staff #3 stated to client #6, "Go get in your chair" and left the room to assist another client. Client #6 wheeled himself to the dining room table near one of the straight chairs and began to transfer himself to the chair. Staff #1 was in the dining room assisting another client. Staff #1 looked over at client #6 and stated, "No, you have to lock your wheels first." Staff #3 returned to the dining room and assisted client #6 with his transfer from his wheel chair into the dining room chair.</p> <p>Client #6's record was reviewed on 9/10/13 at 1 PM.</p>	W000210	<p>On 8/6/13 client #6 had a wheelchair evaluation performed by OT at Forest Ridge, New Castle, IN. Report shows "was able to demonstrate the ability to propel independently as well as transfer from the wheelchair to various surfaces with contact guard". The IDT met on 9/11/13 and determined the need for a PT evaluation. Transfer assist procedure guidelines were also developed on 9/11/13 and put into place. In the future IDT will assess monthly and more frequently as needed each clients mobility needs. Monitoring System: This will be observed by the Home Manager to make sure that the staff assigned to client #6 is on stand by assist when he transfers. This will be checked by the Home Manager daily or every time that she and client #6 are in the home at the same time. The Nurse and QIDP will monitor a minimum of 2 times a month.</p> <p>Responsible person: Direct Care Staff, Home Manager, Nurse, QIDP, IDT All clients have the potential to be affected. All clients ambulatory and mobility needs were assessed at the monthly IDT on 9/11/13.</p>	09/18/2013	

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	<p>__ Client #6's GER (General Events Report) of 9/7/13 at 1:50 PM indicated client #6 was in his bedroom "trying to go" from his wheelchair to his bed and did not lock the wheels on his wheel chair. The report indicated client #6 fell to the floor.</p> <p>__ Client #6's GER of 9/7/13 at 7:15 PM indicated client #6 was in the bathroom and transferring from his wheel chair to the toilet and fell to the floor.</p> <p>__ Client #6's GER of 7/7/13 at 8:40 PM indicated client #6 was in the shower, slipped in the bathroom and injured his toe on his left foot.</p> <p>__ Client #6's GER of 7/7/13 at 8:40 PM indicated client #6 was in his bedroom and was getting up from the wheel chair when the wheel chair moved and client #6 fell to the floor. The report indicated client #6 obtained a "quarter size bruise to left side."</p> <p>__ Client #6's GER of 5/17/13 at 6 PM indicated client #6 sat down "really hard in the shower chair" and hit his buttocks and side of his hips. The report indicated client #6 obtained a "quarter size bruise to left side."</p> <p>__ Client #6's GER of 4/19/13 at 7:35 AM</p>			

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	<p>indicated client #6 was in the dining room and brought his wheel chair up to the dining room chair and did not lock the wheel chair prior to transferring from the chair to the wheel chair and fell to the floor. The report indicated no injuries "at this time."</p> <p>Client #6's ISP (Individual Support Plan) of 5/9/13 indicated client #6 had a diagnosis of, but not limited to, Cerebral Palsy with orthopedic anomalies. Client #6's CFA (Comprehensive Functional Assessment) of 5/8/13 indicated client #6 "is a non-ambulatory individual who uses a wheelchair for mobility. He is able to manipulate the chair throughout the house and workshop, as well as in the community. He does not use the foot rests on his chair as he will 'walk' his chair from place to place. He does have the ability and strength to also move his chair by rotating the wheels of the chair with his hands. He does run into walls and doors and other objects. He will run over objects on the floor. He can independently transfer from, and back to, his wheelchair to toilet, sit in a chair or go to bed. He can bear weight and can stand for short periods of time if he has something to hold on to...."</p> <p>Client #6's 5/9/13 Physical Development and Health section of his CFA indicated</p>						

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	<p>client #6 was "independent w (with)/ transfers when going from w/c (wheelchair) to bed, couch or other seated surface including toilet. [Client #6] is able to stand with assist, is reluctant to bear full wt (weight) on left but will stand on right leg while holding armrest or handicap bars in bath and shower. [Client #6] does not take any steps or attempt to walk in anyway.... [Client #6] has physical orthopedic anomalies, which are bilateral hand contractures (prolonged shortening of the muscles), rt (right) knee contracture, as well as feet and ankle contractures, and abnormal hip alignment.... He (client #6) bruises easily as he is playful with objects in his room simulating building or fixing objects. He (client #6) is not always paying attention when he propels self in wheelchair will bump his forearm or elbow and even knees...."</p> <p>Interview with staff #1 on 9/9/13 at 5:30 PM stated client #6 was independent "for the most part" with transfers from his wheelchair to another chair. Staff #1 stated, "He has had some falls while transferring and he will forget to lock the brakes sometimes." Staff #1 indicated the staff assist client #6 when client #6 needs help.</p> <p>Interview with the RN (Registered Nurse)</p>						

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	<p>on 9/9/13 at 2 PM stated client #6 used a wheelchair for mobility and "in the past" had been independent with transfers to and from the wheelchair "but he seems to be slipping some now." The RN stated over the past few months client #6 has had incidents of falling while transferring and he forgets to lock his wheelchair. "I don't think he's as strong as he used to be." The RN indicated client #6 had a wheelchair evaluation on 8/6/13 to assess if client #6 was in an appropriate wheelchair with the correct supports. The RN indicated client #6's ability to transfer from and to the wheelchair to different surfaces was not assessed by the physical therapist at the evaluation of 8/6/13.</p> <p>Telephone interview with the QIDP (Qualified Intellectual Disabilities Professional) on 9/9/13 at 2:15 PM indicated client #6 had been independent in the past and the IDT had not reassessed client #6's needs in regard to his mobility after the reported incidents of April, May, July and September.</p> <p>9-3-4(a)</p>			

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W000240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on observation, record review and interview for 1 additional client (#6), the client's ISP (Individualized Support Plan) failed to address how the staff were to supervise/monitor and assist client #6 in regard to his mobility, use of the wheelchair and transfers to and from the wheelchair.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 9/9/13 between 3:45 PM and 6:45 PM. Client #6 sat in a wheel chair until time for the evening meal. At 6 PM staff #3 stated to client #6, "Go get in your chair" and left the room to assist another client. Client #6 wheeled himself to the dining room table near one of the straight chairs and began to transfer himself to the chair. Staff #1 was in the dining room assisting another client. Staff #1 looked over at client #6 and stated, "No, you have to lock your wheels first." Staff #3 returned to the dining room and assisted client #6 with his transfer from his wheel chair into the dining room chair.</p> <p>Client #6's record was reviewed on</p>	W000240	<p>A transfer assist procedure was put into place on 9/11/13 for client #6 to include staff stand by assistance when he is transferring. On 10/3/13 the ISP was revised to include monitoring, supervision and assisting client #6 while bathing, dressing, toileting and when transferring to and from his wheelchair. In the future, the ISP will be revisited as needed when changes are identified and will be authorized by the IDT. Monitoring System: The Home Manager, QIDP and Nurse monitor the Direct care Staff that provide client supervision and assistance levels per the ISP. The QIDP reviews the ISP annually and will meet with the Residential Administrator a minimum of quarterly to discuss any necessary changes that are needed throughout the year. In turn those changes will be shared with the IDT. Responsible Party: Direct Care Staff, Home Manager, QIDP, IDT, Residential Administrator</p>	10/03/2013	

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	<p>9/10/13 at 1 PM.</p> <p>__ Client #6's GER (General Events Report) of 9/7/13 at 1:50 PM indicated client #6 was in his bedroom "trying to go" from his wheelchair to his bed and did not lock the wheels on his wheel chair. The report indicated client #6 fell to the floor.</p> <p>__ Client #6's GER of 9/7/13 at 7:15 PM indicated client #6 was in the bathroom and transferring from his wheel chair to the toilet and fell to the floor.</p> <p>__ Client #6's GER of 7/7/13 at 8:40 PM indicated client #6 was in the shower, slipped in the bathroom and injured his toe on his left foot.</p> <p>__ Client #6's GER of 7/7/13 at 8:40 PM indicated client #6 was in his bedroom and was getting up from the wheel chair when the wheel chair moved and client #6 fell to the floor. The report indicated client #6 obtained a "quarter size bruise to left side."</p> <p>__ Client #6's GER of 5/17/13 at 6 PM indicated client #6 sat down "really hard in the shower chair" and hit his buttocks and side of his hips. The report indicated client #6 obtained a "quarter size bruise to left side."</p>						

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	<p>__ Client #6's GER of 4/19/13 at 7:35 AM indicated client #6 was in the dining room and brought his wheel chair up to the dining room chair and did not lock the wheel chair prior to transferring from the chair to the wheel chair and fell to the floor. The report indicated no injuries "at this time."</p> <p>Client #6's ISP (Individual Support Plan) of 5/9/13 indicated client #6 had a diagnosis of, but not limited to, Cerebral Palsy with orthopedic anomalies. Client #6's CFA (Comprehensive Functional Assessment) of 5/8/13 indicated client #6 "is a non-ambulatory individual who uses a wheelchair for mobility. He is able to manipulate the chair throughout the house and workshop, as well as in the community. He does not use the foot rests on his chair as he will 'walk' his chair from place to place. He does have the ability and strength to also move his chair by rotating the wheels of the chair with his hands. He does run into walls and doors and other objects. He will run over objects on the floor. He can independently transfer from, and back to, his wheelchair to toilet, sit in a chair or go to bed. He can bear weight and can stand for short periods of time if he has something to hold on to...."</p> <p>Client #6's 5/9/13 Physical Development</p>			

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	<p>and Health section of his CFA indicated client #6 was "independent w (with)/ transfers when going from w/c (wheelchair) to bed, couch or other seated surface including toilet. [Client #6] is able to stand with assist, is reluctant to bear full wt (weight) on left but will stand on right leg while holding armrest or handicap bars in bath and shower. [Client #6] does not take any steps or attempt to walk in anyway.... [Client #6] has physical orthopedic anomalies, which are bilateral hand contractures (prolonged shortening of the muscles), rt (right) knee contracture, as well as feet and ankle contractures, and abnormal hip alignment.... He (client #6) bruises easily as he is playful with objects in his room simulating building or fixing objects. He (client #6) is not always paying attention when he propels self in wheelchair will bump his forearm or elbow and even knees...."</p> <p>Client #6's ISP did not indicate how the staff were to monitor, supervise and assist client #6 while in and out of the wheelchair throughout the client's day, at the group home and at the workshop. The ISP did not indicate the level of assistance and monitoring required while bathing, dressing, toileting and during all transfers from and to the client's wheelchair.</p>						

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	<p>Interview with staff #1 on 9/9/13 at 5:30 PM stated client #6 was independent "for the most part" with transfers from his wheelchair to another chair. Staff #1 stated, "He has had some falls while transferring and he will forget to lock the brakes sometimes." Staff #1 stated the staff assist client #6 when client #6 needs help, "otherwise, he does it himself."</p> <p>Interview with the RN (Registered Nurse) on 9/9/13 at 2 PM stated client #6 used a wheelchair for mobility and "in the past" had been independent with transfers to and from the wheelchair "but he seems to be slipping some now." The RN stated over the past few months client #6 has had incidents of falling while transferring and "he forgets to lock his wheelchair. I don't think he's as strong as he used to be."</p> <p>Telephone interview with the QIDP (Qualified Intellectual Disabilities Professional) on 9/9/13 at 2:15 PM indicated client #6's ISP was not revised and/or updated after client #6's incidents of April, May, July and September to include how the staff were to monitor, supervise and assist client #6 while in his wheelchair and/or attempting transfers to various chairs or his bed. The QIDP indicated client #6's ISP did not include the level of staff assistance and</p>			

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	<p>monitoring required while client #6 was bathing, dressing, toileting and during all transfers from and to the client's wheelchair.</p> <p>This deficiency was cited on 7/29/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p>			

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W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 1 of 4 sample clients (#1), nursing services failed to address client #1's PT (physical therapy) recommendations and to revise client #1's Falls Risk Plan in regard to use of a gait belt and CGA (Contact Guard Assistance).</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 9/9/13 between 3:45 PM and 6:45 PM. Client #1 walked with a stooped posture and unsteady gait. The staff walked with client #1 from the dining room table to the bathroom and back again. Client #1 got up from his chair, stood for a short time and ambulated toward the front sitting room, turned around and returned to the dining room chair. Staff did not monitor and/or assist client #1 each time client #1 ambulated. Client #1 was not wearing a gait belt during this observation.</p> <p>Client #1's record was reviewed on 9/10/13 at 11 AM. _ Client #1's GER (General Events Report) of 2/1/13 at 12:45 PM indicated client #1 jumped up to go to the</p>	W000331	<p>Client #1's Fall Risk plan was revised on 9/5/13 and included the use of a gait belt and contact guard assist during ambulation. The gait belt was implemented 9/9/13. In the future any PT/OT recommendations that are made which pertain to a client's safety will be implemented immediately. If specialized equipment is recommended for a client the equipment will be ordered immediately. During any lag time between the order for the equipment and the availability of the equipment, staff will be instructed on the best practice to use until the equipment arrives. Monitoring System: Nurse reviews the High Risk Plans Quarterly. Any PT recommendations are reviewed immediately and IDT will monitor all evaluations monthly. The Residential Administrator will meet with the Nurse a minimum of Quarterly to ensure all plans are updated and implemented. No other client was affected and a review of all PT/OT recommendations for each client was reviewed at 9-11-13 IDT meeting. Responsible Party: Nurse, IDT, Residential Administrator</p>	09/11/2013			

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	<p>bathroom, turned to push his chair in and fell backwards, landing on his hands and buttocks. The report indicated the staff were unable to get to client #1 to prevent client #1 from falling. No injuries were reported.</p> <p>__ Client #1's A/I (Accident/Injury) report of 4/3/13 at 7:30 PM indicated the staff thought the floor was dry but it was "still slick." While client #1 was dressing, he sat down on the toilet. The staff went to get something from client #1's bedroom and returned to find client #1 on his "bottom." The report indicated client #1 stated "I fell." No injuries were reported.</p> <p>__ Client #1's GER of 6/19/13 at 8:40 AM indicated client #1 was in the restroom and fell getting onto the toilet causing an abrasion the size of a half dollar. The report did not indicate the location of the abrasion.</p> <p>__ Client #1's A/I report of 7/1/13 at 8 PM indicated client #1 was in the shower sitting on a shower chair. Client #1 went to stand up and fell to his "bottom." No injuries were reported.</p> <p>Client #1's PT evaluation of 9/4/13 indicated "unable to properly assess Pt (patient/client #1) ROM (range of motion)/strength" due to client #1 being "unable to follow simple PT commands." The PT evaluation indicated a recommendation for client #1 to have a</p>			

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NAME OF PROVIDER OR SUPPLIER MCSHERR INC - NEW CASTLE				STREET ADDRESS, CITY, STATE, ZIP CODE 496 DENNY DR NEW CASTLE, IN 47362			
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	<p>gait belt on with CGA whenever client #1 was ambulating. Client #1's record did not indicate the IDT addressed the recommendations of the PT assessment.</p> <p>Client #1's revised Falls risk plan of 8/2013 indicated client #1 was "virtually blind" and "walks with stooped posture and quick pace at times." The plan indicated client #1 had a history of falls and of injuries from bumping into walls and objects due to vision impairment. The plan indicated client #1 was to have "intermittent supervision in the group home. Increased supervision including 1:1 assist will be given during times of increased risk for falls, i.e., evacuation drills, poor weather. Staff are to assist [client #1] to the bathroom during night hours. Staff will escort [client #1] anytime he (client #1) was out in community. This includes taking to workshop door. Staff will give reminders to slow down and tell of obstacles for example 2 steps up, use handrails or avoiding water puddle, etc. Staff will be outside of van/bus door so that they are in front of [client #1] when he is exiting. A second staff can monitor from inside the bus. Staff will give 1:1 assist in the shower for all needs include drying and dressing. [Client #1] is to use a shower chair, a towel is placed on toilet seat after shower while sitting to get dressed." Client #1's Falls risk plan did</p>						

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	<p>not indicate CGA and/or the use of a gait belt.</p> <p>Interview with the facility RN (registered nurse) and the RM (Residential Manager) on 9/10/13 at 2 PM indicated client #1 was blind, walked with a stooped posture and had a history of falls. The RN indicated the RM (residential manager) took client #1 to the PT evaluation and she (the RN) had gotten a gait belt for client #1 to use but was going to wait until the IDT met "tomorrow" and client #1's risk plan was revised/updated and the staff were trained prior to initiating the use of the gait belt and CGA. The RN stated, "It was put on a back burner with everything else going on." The RN stated the recommendations of the PT evaluation "should have" been addressed immediately upon the client returning from the evaluation "and was not." The RM indicated the staff they were to provide client #1 supervision and assistance whenever client #1 was ambulating. The RN indicated the use of the gait belt and CGA would be implemented immediately.</p> <p>This deficiency was cited on 7/29/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p>						

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W009999		W009999	Currently there is no narrative to review? We have left a message for Michelle Young and are submitting corrections for the other 3 deficiencies. Call Jennifer Krodel, CEO at 317-408-6805.Thanks!	10/04/2013	