

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G302		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/30/2013	
NAME OF PROVIDER OR SUPPLIER MCSHERR INC - BACKMEYER				STREET ADDRESS, CITY, STATE, ZIP CODE 3101 BACKMEYER RD RICHMOND, IN 47374			
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: August 21, 22, 23 and 30, 2013.</p> <p>Facility Number: 000821 Provider Number: 15G302 AIMS Number: 100243750</p> <p>Surveyor: Vickie Kolb, RN</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 9/18/13 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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W000149	<p>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 record review and interview for 2 of 4 sample clients (#2 and #4) and 1 additional client (#5), the facility failed to implement its policy and procedures to ensure all allegations of client to client abuse were thoroughly investigated.</p> <p>Findings include:</p> <p>The facility's reportable and investigative records were reviewed on 8/21/13 at 12:30 PM. The facility's BDDS (Bureau of Developmental Disabilities Services) reports indicated:</p> <p>On 4/11/13 at 12 PM while at the workshop, a "staff person witnessed [name of peer] taking a small plastic food container from [client #2]. He (the peer) yelled at her, then threw the container striking [client #2] in the chest. "</p> <p>On 2/27/13 at 11:35 AM while eating lunch, client #4 was smacked on his right shoulder blade by a peer. Client #4 had a 1 1/2 inch red mark on his shoulder.</p> <p>On 2/7/13 at 12:45 PM client #5 was smacked on the head with an open hand by a peer while at the day program.</p>	W000149	<p>All client to client abuse will be reported to the QIDP immediately by telephone. The # is in the home. The QIDP will report this to the House Manager/Residential Director within 5 working days. The report can be made in person, by telephone or by email. In the absence of the QDIP, the home manager will assume this role. The results of the investigation will be reviewed by the Residential Director. They will arrive at a conclusion, possible cause and remedial action which will be initiated immediately. All residents have the potential to be affected by this deficiency. Corrective action Plan in place to protect all consumers. Monitoring System: Any allegations of client to client abuse will be reviewed by the IDT monthly. The QDIP will review the client behavioral data and daily notes a minimum of 2 times per month to assure there are no incidents and to look for possible trends. Responsible Parties: Direct Care Staff, House Manager, QIDP, Residential Director, IDT</p>	09/30/2013	

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	<p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 8/21/13 at 2 PM indicated client to client abuse was only investigated if there was a significant injury and/or the incident was not closed out of BQIS (Bureau of Quality Improvement Services). The QIDP indicated the incidents of client to client abuse reported on 4/11/13, 2/27/13 and 2/7/13 had not been investigated.</p> <p>Review of the undated facility policy "Abuse, Neglect and Exploitation" on 8/21/13 at 2:30 PM indicated abuse to be defined as "Any act that constitutes a violation of the prostitution or criminal sexual conduct statutes, the non-therapeutic conduct that produces or could reasonably be expected to produce pain or injury and is not accidental, or any repeated conduct that produces or could reasonably be expected to produce emotional distress...." The policy indicated client abuse/neglect and/or exploitation is reported to the SW (Social Worker) or designee. The SW or the designee reviews the report and conducts an initial investigation. Upon completion of the investigation, the SW "informs the Residential Director and/or the CEO (Chief Executive Officer) of the initial investigation results."</p>			
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	9-3-2(a)			

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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on interview and record review for 3 of 3 allegations of client to client abuse for clients #2, #4 and #5, the facility failed to provide evidence an investigation was conducted.</p> <p>Findings include:</p> <p>The facility's reportable and investigative records were reviewed on 8/21/13 at 12:30 PM. The facility's BDDS (Bureau of Developmental Disabilities Services) reports indicated:</p> <p>On 4/11/13 at 12 PM while at the workshop, a "staff person witnessed taking [name of peer] taking a small plastic food container from [client #2]. He (the peer) yelled at her, then threw the container striking [client #2] in the chest. "</p> <p>On 2/27/13 at 11:35 AM while eating lunch, client #4 was smacked on his right shoulder blade by a peer. Client #4 had a 1 1/2 inch red mark on his shoulder.</p> <p>On 2/7/13 at 12:45 PM client #5 was smacked on the head with an open hand by a peer while at the day program.</p>	W000154	<p>All client to client abuse will be reported to the QIDP immediately by telephone. The # is in the home. The QIDP will report this to the House Manager/Residential Director within 5 working days. The report can be made in person, by telephone or by email. In the absence of the QDIP, the home manager will assume this role. The results of the investigation will be reviewed by the Residential Director. They will arrive at a conclusion, possible cause and remedial action which will be initiated immediately. All residents have the potential to be affected by this deficiency. Corrective action Plan in place to protect all consumers. Monitoring System: Any allegations of client to client abuse will be reviewed by the IDT monthly. The QDIP will review the client behavioral data and daily notes a minimum of 2 times per month to assure there are no incidents and to look for possible trends. Responsible Parties: Direct Care Staff, House Manager, QIDP, Residential Director, IDT</p>	09/30/2013			

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	<p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 8/21/13 at 2 PM indicated client to client abuse was only investigated if there was a significant injury and/or the incident was not closed out of BQIS (Bureau of Quality Improvement Services). The QIDP indicated the incidents of client to client abuse reported on 4/11/13, 2/27/13 and 2/7/13 had not been investigated.</p> <p>9-3-2(a)</p>			

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W000192	<p>483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>Based on record review and interview for 1 additional client (#7), the facility failed to ensure the staff at the day program were trained on client #4's High Risk plan for seizures and how to use the Diastat pen (a rectal delivery system used for grand mal seizures).</p> <p>Findings include:</p> <p>The facility's reportable and investigative records were reviewed on 8/21/13 at 12:30 PM. The BDDS (Bureau of Developmental Disabilities Services) reports indicated:</p> <p>On 10/13/12 at 7:45 PM client #4 "started having a seizure around 6:30 pm. This seizure lasted more than 15 minutes; therefore, the staff followed [client #4's] seizure protocol and called 911. [Client #4] was still having a seizure when the EMT's arrived at the group home. [Client #4] was taken to the ER. There were no test ran (sic), but [client #4] was given a shot of Ativan to relax him due to him being very tense when he came out of the seizure...."</p>	W000192	<p>Diastat training and all high risk plans for client #4 were taught to Day Service Employees on Sept. 4, 2013. A Post test was given the week of 9/23/13 to assess for retention of information. *All residents have the potential to be affected. Corrective Action Plan in place to protect all residents. Nursing will review quarterly the Day Services health needs of each resident. All training needs identified by the nurse will be addressed with the Day Services Coordinators. Monitoring System: The RN will monitor all residents' health needs quarterly and report Day Services training needs and follow-ups with the IDT on a quarterly basis. Responsible Parties: RN and IDT</p>	09/27/2013	

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	<p>On 11/28/12 at 8:23 AM client #4 began having a grand mal seizure. "[Client #4] was moved to a mat and put on his side. The seizure protocol states that if he has a grand mal seizure lasting 3 minutes or longer to call 911. His face and hands were also bluish-gray in color. 911 was called. He seized for approximately 6 minutes and the convulsions stopped. He was still recovering and had not responded when EMT's arrived a few minutes later. He was transported to the hospital."</p> <p>On 12/7/12 at 5:06 PM "[Client #4] has cerebral palsy and is wheelchair dependent. He was brought to the McSherr Christmas party at approx (approximately) 4:50 pm. He started having a grand mal seizure at 5:05 pm. The McSherr nurse was on site and summoned to help at 1 1/2 minutes into the seizure, [client #4] was cyanotic (a bluish discoloration of the skin resulting from inadequate oxygenation of the blood) and had bit (sic) tongue and showed signs of respiratory distress. 911 was called and 'first responders' arrived within 2 minutes. [Client #4's] convulsion had stopped by the time of their arrival, O2 sat (saturation) 93%, he was having shallow respirations, snoring and not waking to verbal stimuli (post ictal normal for [client #4] for 15 - 30 minutes</p>				

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	<p>afterward). EMT's (Emergency Medical Technicians) on scene within 5 minutes of call and despite the cease of convulsions he was transported to ER. [Client #4] has an order that the transport can be canceled if the seizure activity stops however since the stimuli was not gone (sic) as well as the EMT's reply 'mam (sic) he could have a stroke if he has another one,' knowing many people heard his comment, [client #4] was taken to [name of hospital] and released approx 3 hours afterward with no new orders. [Client #4's] triggers are exposure to cold rain (it was raining), excitement and stress (party with 150 people plus Santa), getting too hot... and fatigue...." The Follow Up BDDS report of 12/10/12 indicated "The IDT (Interdisciplinary Team) met this am and discussed triggers that [client #4] has for seizures. When [client #4] expresses desire to go to a function where the weather is cold and rainy, he will be transported in the smaller van. If that van is not available he will be loaded last and unloaded first when the handicap (sic) van is used. His coat will be removed once inside the building before going to the main area of an event instead of at the dining table.... Also noted that all of [client #4's] seizures are not predictable and he has done well in other times of cold rainy weather with van transportation not being an issue."</p>						

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	<p>On 1/1/13 at 4:45 PM client #4 had a Grand Mal seizure that lasted "just at 3 minutes so 911 was called per Seizure High Risk Plan. [Client #4] became responsive before EMS (Emergency Medical Services) arrived however was having Partial seizure of upper body so he was transported to hospital. No treatment or testing was done, he was given a food tray and released after approx (approximately) 2 hours of observation. Advised (sic) to contact Neurology. Notified [name of doctor] neurologist of another Grand Mal seizure requiring transport to hospital. [Client #4] has had 3 medication changes since mid October."</p> <p>On 3/19/13 at 8:55 AM "[Client #4] began to have a seizure. He stiffened up, his breathing slowed, and his forehead turned purple. He was placed on a mat and turned to his side while staff sat with him. The seizure protocol was followed and 911 was contacted to send an ambulance. His seizure continued until emergency responders arrived." The Follow Up BDDS report of 3/25/13 indicated client #4 was taken to the hospital on 3/19/13 for "precautionary protocol instructions. He had another partial seizure while in the ER was given Ativan (for anxiety)...." Client #4 was released from the hospital back to the</p>				

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	<p>group home with referral to a "local neurologist."</p> <p>On 4/16/13 at 9:04 AM "[Client #4] was on his way to the hospital for labs and a 72 hour EEG application. He had a grand mal seizure and the drive (sic) stopped to give assistance with keeping head up and the seizure stopped briefly but then started again. The driver called McSherr nurse and stated she felt he was having some breathing difficulty during the seizure and was going to call 911, nurse was in agreement. The ER (Emergency Room) doctor spoke to [client #4's] neurologist who ordered Diastat prn (as needed) (for use at Group Home, workshop), etc) for Seizure greater than 5 minutes...."</p> <p>Client #4's record was reviewed on 8/22/13 at 12 PM. Client #4's record indicated diagnoses of, but not limited to, Epilepsy, Spasticity and Cerebral Palsy. Client #4's physician's orders for 7/19/13 indicated client #4 was to have Diazepam gel 10 mg per a rectal pen as needed for grand mal seizure over 3 minutes and could be repeated every 4 - 12 hours as needed. The plan indicated the staff were to follow the instructions as outlined on the Diastat administration instructions that were included with the medication.</p>			

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	<p>Client #4's High Risk Plan for Seizures of July 2013 indicated client #4 "has a history of mixed type seizures including, Grand Mal and partial complex seizures since childhood. [Client #4] is wheelchair dependent. [Client #4] does not have any warnings before his seizures start. [Client #4] relies on the staff for safety and support throughout the day and night." The plan indicated "Diastat will be given for any Grand Mal seizure at 3 minutes if [client #4] is at the group home or workshop." The plan indicated the staff were to call 911 for any grand mal seizure lasting 5 minutes and for partial seizures lasting 30 minutes. The plan indicated the staff were to remain with client #4 at all times during any seizure activity and for 5 minutes post seizure if client #4 was conscious. The staff were to check on client #4 every 5 minutes for 30 minutes after all non-grand mal seizures and the staff were to stay with client #4 for 15 minutes after a grand mal seizure or until awake. The plan did not indicate how the staff were to supervise client #4 during transportation, the type of vehicle that would be used and the number of staff that would be needed during transportation.</p> <p>Client #4's seizure data sheets for 2013 indicated client #4 had 124 seizures from January 2013 through July 2013. The data</p>						

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	<p>sheets indicated 10 of those seizures happened while in the facility vehicle and during transportation activities.</p> <p>Review of the DP (Day Program) training records on 8/23/13 at 1 PM indicated 8 of the 10 DP staff had not been trained on client #4's High Risk plan for seizures and the use of the Diastat pen. The records indicated DP staff #1 and #9 were trained on client #4's risk plan and the use of the Diastat pen on 5/21/13.</p> <p>Interview with DP staff #5 and #8 on 8/23/13 at 11:15 AM indicated staff #5 and #8 did not know client #4 was to have Diastat for seizure activity. DP staff #5 and #8 indicated they did not know what Diastat was and/or how to use it. DP staff #5 and #8 indicated they had not been trained on the use of the Diastat pen.</p> <p>Interview with DP staff #6 and #7 on 8/23/13 at 11:25 AM indicated staff #6 and #7 did not know client #4 was to have Diastat for seizure activity. DP staff #6 and #7 indicated they had not been trained on the use of the Diastat pen.</p> <p>Interview with DP staff #1 on 8/23/13 at 11:30 AM indicated staff #1 did not know client #4 was to have Diastat for seizure activity. DP staff #1 indicated she had been trained on client #4's High Risk plan</p>			

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	<p>for seizures, but could not remember being trained on the use of the Diastat pen.</p> <p>Interview with the DP PC (Program Coordinator) on 8/23/13 at 11:35 AM indicated she had just started her new position and did not know client #4's plan included the use of the Diastat pen. The DP PC indicated she had not received any client specific training in regard to client #4.</p> <p>Interview with the facility RN (Registered Nurse) on 8/23/13 at 1:30 PM indicated she trained the DP staff in regard to the client's medical needs. The RN indicated she had trained the staff at the DP on the use of the Diastat but there had been a turnover of staff and some were on vacation during the training and others were on maternity leave. The RN indicated all staff that worked directly with client #4 at the DP and at the group home were to be trained in regard to client #4's High Risk plan for seizures and the use of the Diastat pen.</p> <p>9-3-3(a)</p>				

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W000228	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs and the planned sequence for dealing with those objectives. Based on record review and interview for 2 of 4 sampled clients (#1 and #4), the clients' ISPs (Individual Support Plans) failed to develop a planned sequence of objectives for the clients to be able to meet their objectives in regard to their financial needs.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 8/22/13 at 9 AM. Client #1's CFA (Comprehensive Functional Assessment) of 10/15/12 indicated client #1 was unable to identify basic coin denominations. Client #1's ISP of 10/15/12 indicated client #1 had an objective to participate in a weekly shopping trip.</p> <p>Client #4's record was reviewed on 8/22/13 at 12 PM. Client #4's CFA (Comprehensive Functional Assessment) of 2/1/13 indicated client #4 was unable to identify basic coin denominations. Client #4's ISP of 2/1/13 indicated once a week, client #4 had an objective go to restaurant and purchase a drink.</p>	W000228	<p>QIDP develops objectives for the clients upon intake and on an annual basis to meet their financial needs and goals. Money Management sequential objectives were revised for client #1 and #4 starting at the basic level of coin identification. Monitoring System: All goals are reviewed quarterly at minimum by the QDIP and House Manager. The Residential Administrator will oversee the QDIP. Goals are updated as applicable. Responsible Parties: Direct Care Staff, House Manager, QIDP, Residential Administrator</p>	10/07/2013			

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	<p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 8/23/13 at 1 PM indicated clients #1 and #4 were not able to identify basic coins without staff assistance. The QIDP indicated clients #1 and #4 were not able to make change and/or to make a simple purchase independently because they were not able to identify and/or understand simple coin combinations. The QIDP stated, "I just thought it was better for them if they got the reward of going out once a week instead of having them sit down and try to identify money."</p> <p>9-3-4(a)</p>			

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W000312	<p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for 2 of 2 sampled clients receiving medications to control behaviors (#1 and #2), the facility failed to ensure a specific plan of reduction was in place to reduce and eventually eliminate the behaviors for which each psychoactive medication was to target.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 8/22/13 at 9 AM.</p> <p>Client #1's 7/16/13 physician's orders indicated client #1 took Sertraline (Zoloft - an antipsychotic) 50 mg (milligrams) a day for behavior modification and a PRN (as needed) of Olanzapine 10 mg for "extreme physical aggression." Client #1's BSP (Behavior Support Plan) of 4/8/13 indicated client #1 had targeted behaviors of non-cooperation, self injurious behavior and physical aggression. Client #1's BSP indicated no plan of reduction for the use of the Zoloft.</p>	W000312	All clients receiving psychotropic meds have the potential to be affected, therefore a quarterly review will be conducted to develop a thorough Medication Reduction Plan. Clients #1 and #2 Medication Reduction Plans were revised to address the reduction and eventual elimination of behaviors and drugs prescribed. The QIDP and Behavioral Consultant will review the Medication Reduction Plans quarterly in conjunction with review of behavioral objectives. Monitoring System: The QIDP and Behavioral Consultant will report to the IDT post quarterly review. The Residential Administrator will oversee the QIDP. Responsible Parties: QIDP, Residential Administrator, Behavior Consultant and IDT	10/07/2013	

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	<p>Client #2's record was reviewed on 8/22/13 at 10 AM. Client #2's 8/6/13 physician's orders indicated client #2 took Bupropion (an antidepressant) 100 mg a day and Abilify (an antipsychotic) 15 mg a day for behavior modification. Client #2's BSP of 7/15/13 indicated client #2 had targeted behaviors of non-cooperation, Bruxism (grinding her teeth) and property misuse. Client #2's BSP did not indicate which behaviors the Bupropion and Abilify were to target. Client #2's BSP indicated no plan of reduction for the use of the Abilify.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 8/22/13 at 11 AM indicated client #1's BSP did not include a plan of reduction for the Zoloft. The QIDP indicated client #2's BSP did not specify the behaviors for each medication client #2 took for behavior modification. The QIDP indicated client #2's BSP did not include a plan of reduction for the Abilify.</p> <p>9-3-5(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 (#4) and 1 additional client (#7), the nursing services failed to ensure:</p> <p>__ The staff at the day program were trained on the use of client #4's Diastat (rectal delivery system pen used for grand mal seizures).</p> <p>__ Client #4's risk plan for seizures included how many staff were required to transport client #4 and how the staff were to provide supervision and medical assistance during transportation.</p> <p>__ The staff followed client #7's diabetic risk plan.</p> <p>Findings include:</p> <p>1. During observations at the group home on 8/21/13 between 4 PM and 6:30 PM and on 8/22/13 between 6 AM and 7:30 AM, client #4 sat in a wheel chair. The staff assisted client #4 with his AM care, meals, toileting and maneuvering the wheel chair in and out of the home.</p> <p>The facility's reportable and investigative records were reviewed on 8/21/13 at 12:30 PM. The BDDS (Bureau of Developmental Disabilities Services) reports indicated:</p>	W000331	<p>Diastat training and all high risk plans for client #4 were taught to Day Service Employees on Sept. 4, 2013. A Post test was given the week of 9/23/13 to assess for retention of information to Day Service Staff. Client #4 seizure risk plan has been revised to include medical assistance during transportation. Client #7 's diabetic risk plan has been retrained and a post test given to all staff.*All residents have the potential to be affected. Corrective Action Plan in place to protect all residents.Nursing will review quarterly the Day Services health needs of each resident. All training needs identified by the nurse will be addressed with the Day Services Coordinators. Nursing will also review Client #7's blood sugar tracking sheet weekly to ensure that they are being double checked per hypoglycemic protocol.Monitoring System: The RN will monitor all residents' health needs quarterly and report Day Services training needs and follow-ups with the IDT on a quarterly basis. Blood sugar tracking sheet will be checked weekly by the RN and/or House Manager.Responsible Parties: RN, House Manager, and IDT</p>	10/01/2013	

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	<p>On 10/13/12 at 7:45 PM client #4 "started having a seizure around 6:30 pm. This seizure lasted more than 15 minutes; therefore, the staff followed [client #4's] seizure protocol and called 911. [Client #4] was still having a seizure when the EMT's arrived at the group home. [Client #4] was taken to the ER. There were no test ran (sic), but [client #4] was given a shot of Ativan to relax him due to him being very tense when he came out of the seizure...."</p> <p>On 11/28/12 at 8:23 AM client #4 began having a grand mal seizure. "[Client #4] was moved to a mat and put on his side. The seizure protocol states that if he has a grand mal seizure lasting 3 minutes or longer to call 911. His face and hands were also bluish-gray in color. 911 was called. He seized for approximately 6 minutes and the convulsions stopped. He was still recovering and had not responded when EMT's arrived a few minutes later. He was transported to the hospital."</p> <p>On 12/7/12 at 5:06 PM "[Client #4] has cerebral palsy and is wheelchair dependent. He was brought to the McSherr Christmas party at approx (approximately) 4:50 pm. He started having a grand mal seizure at 5:05 pm.</p>			

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	<p>The McSherr nurse was on site and summoned to help at 1 1/2 minutes into the seizure, [client #4] was cyanotic (a bluish discoloration of the skin resulting from inadequate oxygenation of the blood) and had bit (sic) tongue and had bit tongue and showed signs of respiratory distress. 911 was called and 'first responders' arrived within 2 minutes. [Client #4's] convulsion had stopped by the time of their arrival, O2 sat (saturation) 93%, he was having shallow respirations, snoring and not waking to verbal stimuli (post ictal normal for [client #4] for 15 - 30 minutes afterward). EMT's (Emergency Medical Technicians) on scene within 5 minutes of call and despite the cease of convulsions he was transported to ER. [Client #4] has an order that the transport can be canceled if the seizure activity stops however since the stimuli was not gone (sic) as well at the EMT's reply 'mam (sic) he could have a stroke if he has another one,' knowing many people heard his comment, [client #4] was taken to [name of hospital] and released approx 3 hours afterward with no new orders. [Client #4's] triggers are exposure to cold rain (it was raining), excitement and stress (party with 150 people plus Santa), getting too hot... and fatigue...." The Follow Up BDDS report of 12/10/12 indicated "The IDT (Interdisciplinary Team) met this am and</p>			

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	<p>discussed triggers that [client #4] has for seizures. When [client #4] expresses desire to go to a function where the weather is cold and rainy, he will be transported in the smaller van. If that van is not available he will be loaded last and unloaded first when the handicap (sic) van is used. His coat will be removed once inside the building before going to the main area of an event instead of at the dining table.... Also noted that all of [client #4's] seizures are not predictable and he has done well in other times of cold rainy weather with van transportation not being an issue."</p> <p>On 1/1/13 at 4:45 PM client #4 had a Grand Mal seizure that lasted "just at 3 minutes so 911 was called per Seizure High Risk Plan. [Client #4] became responsive before EMS (Emergency Medical Services) arrived however was having Partial seizure of upper body so he was transported to hospital. No treatment or testing was done, he was given a food tray and released after approx (approximately) 2 hours of observation. Advised (sic) to contact Neurology. Notified [name of doctor] neurologist of another Grand Mal seizure requiring transport to hospital. [Client #4] has had 3 medication changes since mid October."</p> <p>On 3/19/13 at 8:55 AM "[Client #4]</p>			
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	<p>began to have a seizure. He stiffened up, his breathing slowed, and his forehead turned purple. He was placed on a mat and turned to his side while staff sat with him. The seizure protocol was followed and 911 was contacted to send an ambulance. His seizure continued until emergency responders arrived." The Follow Up BDDS report of 3/25/13 indicated client #4 was taken to the hospital on 3/19/13 for "precautionary protocol instructions. He had another partial seizure while in the ER was given Ativan (for anxiety)...." Client #4 was released from the hospital back to the group home with referral to a "local neurologist."</p> <p>On 4/16/13 at 9:04 AM "[Client #4] was on his way to the hospital for labs and a 72 hour EEG application. He had a grand mal seizure and the drive (sic) stopped to give assistance with keeping head up and the seizure stopped briefly but then started again. The driver called McSherr nurse and stated she felt he was having some breathing difficulty during the seizure and was going to call 911, nurse was in agreement. The ER (Emergency Room) doctor spoke to [client #4's] neurologist who ordered Diastat prn (as needed) (for use at Group Home, workshop), etc) for Seizure greater than 5 minutes...."</p>			

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	<p>Client #4's record was reviewed on 8/22/13 at 12 PM. Client #4's record indicated diagnoses of, but not limited to, Epilepsy, Spasticity and Cerebral Palsy. Client #4's physician's orders for 7/19/13 indicated client #4 was to have Diazepam gel 10 mg per a rectal pen as needed for grand mal seizure over 3 minutes and could be repeated every 4 - 12 hours as needed. The plan indicated the staff were to follow the instructions as outlined on the Diastat administration instructions that were included with the medication.</p> <p>Client #4's High Risk Plan for Seizures of July 2013 indicated client #4 "has a history of mixed type seizures including, Grand Mal and partial complex seizures since childhood. [Client #4] is wheelchair dependent. [Client #4] does not have any warnings before his seizures start. [Client #4] relies on the staff for safety and support throughout the day and night." The plan indicated "Diastat will be given for any Grand Mal seizure at 3 minutes if [client #4] is at the group home or workshop." The plan indicated the staff were to call 911 for any grand mal seizure lasting 5 minutes and for partial seizures lasting 30 minutes. The plan indicated the staff were to remain with client #4 at all times during any seizure activity and for 5 minutes post seizure if client #4 was</p>				

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	<p>conscious. The staff were to check on client #4 every 5 minutes for 30 minutes after all non-grand mal seizures and the staff were to stay with client #4 for 15 minutes after a grand mal seizure or until awake. The plan did not indicate how the staff were to supervise client #4 during transportation, the type of vehicle that would be used and the number of staff that would be needed during transportation.</p> <p>Client #4's seizure data sheets for 2013 indicated client #4 had 124 seizures from January 2013 through July 2013. The data sheets indicated 10 of those seizures happened while in the facility vehicle and during transportation activities.</p> <p>Review of the DP (Day Program) training records on 8/23/13 at 1 PM indicated 8 of the 10 DP staff had not been trained on client #4's High Risk plan for seizures and the use of the Diastat pen. The records indicated DP staff #1 and #9 were trained on client #4's risk plan and the use of the Diastat pen on 5/21/13.</p> <p>Interview with DP staff #5 and #8 on 8/23/13 at 11:15 AM indicated staff #5 and #8 did not know client #4 was to have Diastat for seizure activity. DP staff #5 and #8 indicated they did not know what Diastat was and/or how to use it. DP staff</p>				

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	<p>#5 and #8 indicated they had not been trained on the use of the Diastat pen.</p> <p>Interview with DP staff #6 and #7 on 8/23/13 at 11:25 AM indicated staff #6 and #7 did not know client #4 was to have Diastat for seizure activity. DP staff #6 and #7 indicated they had not been trained on the use of the Diastat pen.</p> <p>Interview with DP staff #1 on 8/23/13 at 11:30 AM indicated staff #1 did not know client #4 was to have Diastat for seizure activity. DP staff #1 indicated she had been trained on client #4's High Risk plan for seizures, but could not remember being trained on the use of the Diastat pen.</p> <p>Interview with the DP PC (Program Coordinator) on 8/23/13 at 11:35 AM indicated she had just started her new position and did not know client #4's plan included the use of the Diastat pen. The DP PC indicated she had not received any client specific training in regard to client #4.</p> <p>Interview with the facility RN (Registered Nurse) on 8/23/13 at 1:30 PM indicated she trained the DP staff in regard to the client's medical needs. The RN indicated she had trained the staff at the DP on the use of the Diastat but there had been a</p>			

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	<p>turnover of staff and some were on vacation during the training and others were on maternity leave. The RN indicated all staff that worked directly with client #4 at the DP and at the group home were to be trained in regard to client #4's High Risk plan for seizures and the use of the Diastat pen. The RN indicated when the facility minivan was used to transport client #4, only one staff would go with client #4. The RN stated she had driven behind the facility vehicle "on a few occasions" when client #4 was being transported because she was "afraid" client #4 would go into a seizure during transportation. The RN indicated client #4's risk plan did not include staff supervision, monitoring and number of staff needed during transportation.</p> <p>2. Observations were conducted at the facility group home on 8/22/13 between 6 AM and 7:30 AM. At 6:05 AM client #7 tested her blood sugar with a glucometer. Client #7 got a reading of 57. Staff #5 gave client #7 a tube of glucose gel. Client #7 took the tube of glucose and walked away from the medication area. At 6:10 AM client #7 made her breakfast and sat down to eat. At 7:50 AM, after eating her breakfast, client #7 took her blood sugar again. Client #7's blood sugar was 236. Staff #5 observed client #7 as she gave herself 10 units of Humalog</p>			
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	<p>insulin and 36 units of Lantus insulin. The staff did not recheck client #7's blood sugar after getting a reading below 60. Staff #5 did not follow client #7's diabetic protocol.</p> <p>Client #7's record was reviewed on 8/22/13 at 1:30 PM.</p> <p>Client #7's Hypoglycemia Protocol of 7/15/13 indicated if client #7's blood sugar was less than 60, "recheck," if still below 60 then give glucose gel - 15 grams of carbohydrates.... Recheck blood sugar in 30 minutes. If still below 60... If it is mealtime the [client #7] should go ahead and eat. If it is not mealtime and still below 60, repeat glucose gel and call the nurse."</p> <p>Client #7's BSR (Blood Sugar Readings) data sheet for August 2013 indicated client #7's blood sugar was below 60 on August 2 and 22. Client #7's BSR data sheets did not indicate client #7's blood sugar was rechecked per client #7's diabetic protocol on 8/2/13 and on 8/22/13.</p> <p>Interview with the RN on 8/22/13 at 1:30 PM indicated the staff were to follow client #7's diabetic protocol. The RN indicated when client #7's blood sugar was below 60, the staff were to recheck</p>				

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NAME OF PROVIDER OR SUPPLIER MCSHERR INC - BACKMEYER	STREET ADDRESS, CITY, STATE, ZIP CODE 3101 BACKMEYER RD RICHMOND, IN 47374
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	<p>client #7's reading and to follow the protocol. The RN reviewed the BSR data sheet for August and stated, "Looks like I need to revise this sheet to include a space to document the recheck."</p> <p>9-3-6(a)</p>			
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W000371	<p>483.460(k)(4) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. Based on record review and interview for 3 of 4 sampled clients (#1, #3 and #4), the facility failed to develop medication objectives that provided medication training.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 8/22/13 at 9 AM. Client #1's August 2013 physician's orders indicated client #1 took the following prescribed medications: ___ Sertraline 50 mg (milligrams) qd (once a day) for behavior modification. ___ Polyethylene Glycol 17 gms (grams) qd for bowel stimulation. ___ Sodium Bicarbonate 650 mg qd and Omeprazole 20 mg bid (twice a day) to reduce stomach acid. ___ A multivitamin qd for dietary supplementation. ___ Loratadine 10 mg qd for seasonal allergies. ___ Levothyroxine 112 mcg (micrograms) qd for hypothyroidism. ___ Lamotrigine 100 mg bid for seizures. Client #1's CFA (Comprehensive</p>	W000371	<p>The QIDP initiated a drug administration plan for Client# 1, #3, and #4 on Sept. 3, 2013. All Clients' plans were reviewed to ensure that they have a medication administration objective that provides medication training. Monitoring System: In the future, the QIDP will ensure that all clients will have a medication administration IPP in place and it will be reported at the annual IHP. All IDT members will sign off on this. Responsible Parties: QIDP and IDT</p>	09/03/2013			

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	<p>Functional Assessment) of 10/15/12 indicated client #1 did not "self medicate." Client #1's ISP of 10/15/12 indicated staff assisted client #1 with all medications. Client #1's ISP indicated no training objectives to assist client #1 with taking and/or identifying her medications.</p> <p>Client #3's record was reviewed on 8/22/13 at 11 AM. Client #3's August 2013 physician's orders indicated client #3 took the following prescribed medications daily: __ Sprintec 28 qd for menstrual irregularities. __ Lisinopril 40 mg and Hydrochlorothiazide 25 mg qd for high blood pressure. __ Cetirizine 10 mg qd for allergic rhinitis.</p> <p>Client #3's CFA of 3/1/13 indicated client #3 did not "self medicate." Client #3's ISP of 10/15/12 indicated staff assisted client #3 with all medications. Client #3's ISP indicated no training objectives to assist client #3 with taking and/or identifying her medications.</p> <p>Client #4's record was reviewed on 8/22/13 at 12 PM. Client #2's August 2013 physician's orders indicated client #2 took the following prescribed medications daily: __ Cetirizine 10 mg qd for allergic</p>				

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	<p>rhinitis.</p> <p>__ Banzel 1200 mg bid, Levetiracetam 750 mg bid and Lamotrigine 250 mg bid for seizures.</p> <p>Client #4's CFA of 2/1/13 indicated client #1 did not "self medicate." Client #4's ISP of 2/1/13 indicated staff assisted client #4 with all medications. Client #4's ISP indicated no training objectives to assist client #4 with taking and/or identifying his medications.</p> <p>Interview with the facility RN (registered nurse) on 8/22/13 at 1 PM stated clients #1, #3 and #4 were not able to identify their medications, but "would benefit from training." The facility RN stated client #1 was capable of more than "just going to the med area."</p> <p>During interview with the QIDP (Qualified Intellectual Disabilities Professional) on 8/23/13 at 2 PM, the QIDP indicated client #1 had an objective to come to the medication area for her medications, client #3 was provided training to take her blood pressure and client #4 was to mark out his name with a marker on the medication envelope. The QIDP indicated clients #1, #3 and #4 were not independent in taking medications and required staff assistance to identify, prepare and give clients #1, #3 and #4 all of their medications. The QIDP</p>						

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	<p>stated client #1's, #3's and #4's ISP objectives did not provide the clients "specific" training in identifying and taking their medications.</p> <p>9-3-6(a)</p>			

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W009999	<p>STATE FINDINGS</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met.</p> <p>460 IAC 9-3-1 Governing Body (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by division.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 1 of 4 sample clients (#1), the facility failed to notify the Bureau of Developmental Disabilities Services (BDDS) within 24 hours in accordance with state law regarding the use of general anesthesia for a gynecological exam.</p> <p>Findings include:</p> <p>Review of the facility HRC (Human Rights Committee) notes for 2013 at 8/21/13 at 1 PM indicated client #1 required a general anesthesia for a "female exam" on 1/15/13.</p>	W009999	<p>Client #1 had a female exam under a GA on 8/21/13. McSherr's HRC and Client #1's guardian had been notified of this procedure and had approved the GA. A BDDS report was not filed; however, in the future all procedures that requires a GA will be reported. Monitoring System: RN will notify the Social Worker upon patient recover of the GA. The Social Worker will report all procedures that require a GA within 24 hours the GA is given. The Social Worker will report all GA reports to the IDT when they occur. Responsible Parties: RN, SW, and IDT</p>	09/30/2013			

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	<p>The facility's reportable records were reviewed on 8/21/13 at 12:30 PM. The facility records indicated no reports for client #1 in regard to the need for sedation for a gynecological exam.</p> <p>Interview with the facility RN (Registered Nurse) on 8/22/13 at 2 PM indicated client #1's gynecological exam on 1/15/13 was conducted under general anesthesia because clients #1 was uncooperative with the procedure and required sedation.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 8/23/13 at 2 PM indicated client #1's 1/15/13 need for sedation for a gynecological exam was not reported to BDDS.</p> <p>9-3-1(b)</p>				