

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 04/08/2016
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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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W 0000 Bldg. 00	<p>This visit was for the investigation of complaint #IN00195974.</p> <p>Complaint #IN00195974: SUBSTANTIATED, Federal and State deficiencies related to the allegations were cited at W149, W153, W154, and W331.</p> <p>Unrelated deficiency cited.</p> <p>Dates of Survey: 3/30, 3/31, 4/1, 4/4, 4/5, 4/6, 4/7, and 4/8/2016.</p> <p>Facility number: 001093 Provider number: 15G579 AIM number: 100239970</p> <p>These federal deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 4/13/16.</p>	W 0000		
W 0149 Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>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 1 of 3 sampled clients (client A), the facility neglected to implement their</p>	W 0149	<p>Name and Address of Provider: McSherr, Inc., 496Denny Drive, New Castle, IN</p> <p>Date Survey Completed:</p>	05/08/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>policy for abuse, neglect, and/or mistreatment to accurately report and to thoroughly investigate client A's unknown bruises.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and investigations from 12/1/2015 through 3/30/2016 were reviewed on 3/30/16 at 7:30pm and indicated no report which included client A had unknown bruises on his body.</p> <p>-A 3/10/16 BDDS report for an incident on 3/9/16 at 8:40am indicated "When the HM (House Manager) came into the group home the morning of 3/9/16 she noticed that [client A] appeared to be having a hard time breathing and there was a gurgling sound when he breathed." The report indicated the HM called 9-1-1, client A was transported by ambulance to the hospital, and was later placed on a ventilator. The report did not indicate client A had unknown bruises on his body.</p> <p>-A 3/24/16 Follow Up BDDS report to the incident on 3/9/16 at 8:40am indicated client A had been transferred from Hospital #1 to Hospital #2 on 3/10/16 and his "liver enzymes were 700</p>		<p>4/8/2016</p> <p>Provider Identification Number: 15G579</p> <p>Survey Event ID: WHZW11</p> <p>Finding: W149– The facility neglected to implement their policy for abuse, neglect, and/or mistreatment to accurately report and to thoroughly investigate client A's unknown bruises.</p> <p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> · Client A is under the care of a Hematologist and his PCP · Social Services Coordinator, Residential Administrator, and Health Services Coordinator re-trained Denney Drive staff on completing body check daily and completing form accurately · Lead Staff and/or House Manager will compare completed daily body checks to Accident and Injury Reports where bruises are reported and investigated if unknown. · Staff that did not correctly complete Daily Body Check Form were counseled · All unknown bruises, even when discovered while hospitalized and attributed to an illness, will be reported to BDDS and APS and will be investigated per policy, BDDS incident reporting guidelines, and state and federal laws 	

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	<p>and normal is 30-50." The report indicated client A's "liver problems were causing the blood issues...." The report indicated client A was taken off the ventilator on 3/14/16 and a "diagnosis that was given to [client A] was alter (sic) mental status, respiratory failure resolved, and Thrombocytopenia (a deficiency of platelets in the blood. This causes bleeding into the tissues, bruising, and slow blood clotting after injury) resolved." The report indicated client A was transferred back to the group home on 3/20/16. The report did not indicate client A had unknown bruises on his body.</p> <p>-A 2/28/16 BDDS report for an incident on 2/27/16 at 11:15am indicated client A "was shaking all over, appeared to be weak, and would not stand. He kept sitting on the floor stating that his legs didn't work." The report indicated after staff assisted him to sit on the sofa that client A "would not respond" to staff and client A was transported by ambulance to Hospital #1. The report indicated the hospital testing "didn't show anything definitely wrong...[The Doctor] was guessing at this point that it was a virus of some sort." The report did not indicate client A had unknown injuries and/or bruises on his body.</p>		<ul style="list-style-type: none"> ·HealthServices Coordinator has added risk of bruising to Client A's High Risk Plan ·HealthServices Coordinator has added written guidelines for walking difficulties to Client A's High Risk Plan to address issues when they arise ·Interviewsare reviewed by RA and at IDT to screen for potential abuse/neglect ·AllDenney Drive staff have been retrained on Suspected Abuse, Neglect &Exploitation and Incident Reporting and were tested to ensure they haveretained the information <p>Howwill you identify other residents having the potential to be affected by thesame deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·Allconsumers have the potential to be affected. ·DenneyDrive staff that do not report as tasked per McSherr policy, BDDS regulations, and state law will be disciplined per McSherr Policy, BDDS regulations, andstate law pertaining to Suspected Abuse and Neglect and Incident Reporting · reports of or suspicion of abuse and/orneglect will be investigated and reported to BDDS ·AllDenney Drive staff have been retrained on Suspected Abuse, Neglect &Exploitation and 	

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	<p>On 3/31/16 at 8:00am, client A's 3/9/16 Hospital #1 "Discharge Summary" was reviewed. Hospital #1's Discharge Summary indicated "Hospital Course...Patient had previously also been complaining of overall weakness, vomiting and about 1 week prior had a fever as well as developing some bruising. However, for none of this was found out really why (sic)...Physical Examination...Skin shows several areas of ecchymosis (a discoloration of the skin resulting from bleeding underneath, typically caused by bruising) on his back as well as a new type of maybe some scabbing on his back. Areas of bruising that sometimes appear like handgrips on the side of the back of the leg. The staff said that this also occurred approximately 1 week ago. He had a follow up with a hematologist, but otherwise there was nothing found about it...."</p> <p>On 3/31/16 at 1:00pm, client A's 3/10/16 Hospital #2 "Social Work Progress Notes" indicated "Final Report...[Client A's name of Doctor] and [client A's] nurse reported having concerns about bruising on the patient's legs and hips that are (sic) in different stages of healing... [Name of Doctor] stated patient has low platelet count but no witness (sic) seizures to explain bruising and recommended APS (Adult Protective</p>		<p>Incident Reporting and tested to make sure they have retained the information</p> <ul style="list-style-type: none"> ·HighRisk Plans are reviewed quarterly to ensure potential areas of risk are covered ·DenneyDrive staff were re-trained on completing Daily Body Checks thoroughly ·LeadStaff and/or House Manager will compare Daily Body Checks to Accident and Injury Reports weekly to ensure consistency in reporting bruises and other injuries <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?)</p> <ul style="list-style-type: none"> ·DenneyDrive staff that do not report as tasked per McSherr policy, BDDS regulations, and state law will be disciplined per McSherr Policy, BDDS regulations, and state law pertaining to Suspected Abuse and Neglect and Incident Reporting ·All Denney Drive staff have been retrained on Suspected Abuse, Neglect & Exploitation and Incident Reporting and tested to make sure they have retained the information ·HighRisk Plans are reviewed quarterly to ensure potential areas of risk are covered ·DenneyDrive staff were re-trained on completing Daily Body Checks thoroughly 	

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	<p>Services) report."</p> <p>-Client A's 3/14/16 Hospital #2 "Case Management Notes" indicated client A had a legal guardian and client A's guardian had "shared...she was aware of bruising and shared that patient has been bruising easily over the past several weeks and has a hematology appointment schedule (sic) to investigate this further." The report indicated "guardian has no concerns re (regarding): patient care at the group home."</p> <p>-Client A's 3/10/16 Hospital #2 "Critical Care Progress Note" indicated client A had "Multiple bruises: Foot x-ray, no fracture...Integumentary (condition of the skin): Warm, dry, intact, excoriations/scratches along inner thighs bilaterally, Bruise on R (right) middle toe, Bruises along elbows and forearms bilaterally."</p> <p>-Client A's 3/10/16 Hospital #2 "Internal Med Resident Initial Consult" indicated client A was admitted from Hospital #1 and had "...Multiple bruises all over. XR (X-Ray) right foot third digit...."</p> <p>-Client A's 3/10/16 Hospital #2 "Nursing Assessment" indicated "...Bruising all over patient body with various stages of bruise (sic)...Bruising all over chest,</p>		<ul style="list-style-type: none"> ·LeadStaff and/or House Manager will compare Daily Body Checks to Accident and Injury Reports weekly to ensure consistency in reporting bruises and otherinjuries ·Unknownbruises, even when hospitalized and attributable to illness or disease, will bereported to BDDS and APS ·SocialServices Coordinator currently interviews all clients and staff quarterly todetermine if there is any suspected abuse or neglect that may be reportable ·Quarterlyinterviews are reviewed by the RA and team at monthly IDT meetings to screenfor suspected abuse/neglect ·ALLAccident and Injury reports are now sent to Social Services Coordinator at thecorporate office, reviewed with the Residential Administrator and HealthServices Coordinator, and signed to ensure they have been reviewed to screenfor suspected abuse/neglect <p>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?</p> <ul style="list-style-type: none"> ·HighRisk Plans are reviewed quarterly to ensure potential areas of risk are covered ·DenneyDrive staff were re-trained on completing Daily Body Checks thoroughly 	

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	<p>arms, legs, and hips...."</p> <p>Client A's group home record was reviewed on 3/31/16 at 9:45am. Client A's 3/21/16 ISP (Individual Support Plan), 3/2016 Risk Plans, and 3/2016 BSP (Behavior Support Plan) did not indicate client A was at risk for bruising. Client A's 11/13/15, 4/29/15, and 1/24/15 "Nursing Quarterly" assessments did not indicate client A was at risk for bruising, or had problems with bruising, or unknown injuries. Client A's "Daily Body Checks" indicated "Inspect the entire naked body at bath time each day. If a bruise, scratch, or other marks (sic) is found, place a number in the appropriate column...Place the same number on the body chart to indicate location. Detailed description (sic) need to be documented on the back of the sheet. All unknown injuries are to be reported immediately to the house manager." The "Daily Body Checks" form for the period from 3/1/16 through 3/21/16 indicated he did not have bruising or injuries to his skin.</p> <p>On 3/30/16 at 4:45pm, an interview with the House Manager (HM) was conducted. The HM stated when she came into the group home on 3/9/16, client A was in his bedroom, and his breathing "sounded like gurgling." The HM indicated client A needed two people to assist him, so she</p>		<ul style="list-style-type: none"> ·LeadStaff and/or House Manager will compare Daily Body Checks to Accident and Injury Reports weekly to ensure consistency in reporting bruises and other injuries ·Quarterly interviews are reviewed by the RA and team at monthly IDT meetings to screen for suspected abuse/neglect ·ALL Accident and Injury reports are now sent to Social Services Coordinator at the corporate office, reviewed with the Residential Administrator and Health Services Coordinator, and signed to ensure they have been reviewed to screen for suspected abuse/neglect <p>What is the date by which the systemic changes will be completed? 5/8/16</p> <p>Respectfully Submitted, Rosemary Taylor, Residential Administrator</p>	

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	<p>and another staff helped dress client A, and "I saw bruises" on client A's body. The HM stated client A had "bruised easily" for several weeks. The HM indicated client A had no risk plan to address his bruising. The HM stated client A "had bruises under both arms" in his arm pits from staff assisting client A to walk, client A had "new" bruising on his back, the top of his legs, and "I had not seen all those bruises on [client A's] legs." The HM indicated staff were to track all bruises and injuries on the daily skin sheets. The HM indicated an accident/injury report was to be filled out and an investigation would be initiated. The HM indicated she was unaware of any accident/injury report or investigation for these bruises.</p> <p>On 3/31/16 at 11:50am, an interview with the Residential Administrator (RA) was conducted. The RA indicated client A had experienced incidents in February, 2016 "when [client A] did not want to walk" and had dropped to his knees which could have caused some bruising. The RA indicated client A had an incident the end of February, 2016 that injured his right toe, client A had crawled on the floor, and had marks on his hands from the incident. The RA stated "all injuries of unknown origin" were reported and investigated. The RA</p>			

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	<p>indicated the agency reported the hospitalization for client A and the BDDS report did not indicate client A's unknown bruising. The RA indicated she witnessed client A's bruising when she was at the hospital with him on 3/9/16 at hospital #1 and again on 3/10/16 at hospital #2. The RA stated "it was like he was bruising as we looked at him" laying in the hospital bed.</p> <p>-The RA provided a 3/9/16 administrative summary narrative report which indicated "Morning of 3/9/16 RA was notified by HM that [client A] was being transported to hospital via ambulance after HM called 9-1-1 when breathing difficulty was noted. RA arrived at [name of Hospital #1] and saw HM sitting in hallway outside of nursing station in ER (Emergency Room)...HM stated that when she arrived at the home [client A] was still in his room in his bed. She tried talking to [client A] and he was attempting to talk but she could only understand one word. Within minutes she reports noticing breathing difficulties and heard a gurgling sound. HM decided at that time to call 9-1-1. [Client A] was transported to Emergency Room...Both RA and ER staff noted brownish bruises covering [client A's] body, chest, legs, etc... RA asked HM about the bruising and HM stated that she noticed some</p>			
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	<p>small bruises on Monday and an A&I (Accident & Injury report) was completed. She thought they may have been caused by staff assisting [client A] with ambulation since he had experienced difficulty after his ER visit the week before. HM stated that after IDT (Interdisciplinary Team) meeting on 3/8/16, she received a call from [client A's doctor] stating he wanted [client A] to see a Hematologist as some of his labs were abnormal."</p> <p>On 3/31/16 at 11:50am, the RA stated client A's "Bruising was worse at the hospital," client A "was covered in bruises," and the bruising improved in one to two days. The RA indicated client A did not have a nursing protocol and no documentation was available for review of client A's bruises and unknown injuries. The RA indicated the facility followed the BDDS reporting and investigating policy to immediately report and to thoroughly investigate unknown injuries.</p> <p>On 3/31/16 at 11:13am, an interview with the Agency's Registered Nurse (RN) was conducted. The RN indicated client A's bruises from his previous injuries and unknown bruises were not recorded on client A's "Daily Skin Sheets" and should have been documented. The RN</p>			

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	<p>indicated the BDDS report documented client A's hospitalizations and did not report his unknown bruises. The RN indicated he was unaware of any documented investigation regarding client A's unknown bruises/injuries. The RN indicated client A did not have a nursing plan on how to assist client A when he was unable to walk independently. The RN indicated client A was able to walk independently with a walker before client A became ill. The RN indicated client A had no risk plan developed to address his skin problems related to his liver problems and to give staff written guidelines for assisting client A with his nursing care needs.</p> <p>On 3/31/16 at 11:30am, the facility's undated "Suspected abuse, neglect, or exploitation Policy" indicated the agency prohibited abuse and neglect. The policy indicated "...Signs of physical, psychological abuse/neglect: Signs of physical abuse: Unexplained broken bones, bruising...Any suspicion of abuse, neglect, exploitation, or mistreatment of a consumer or violation of the consumer's rights, the staff learning of such shall immediately inform their immediate supervisor."</p> <p>On 3/31/16 at 8:15am, the 10/2005 "Bureau of Developmental Disability</p>			

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W 0153 Bldg. 00	<p>Services Policy and Guidelines." The BDDS policy and procedure indicated "...Abuse, Neglect, and Mistreatment of Individuals...it is the policy of the company to ensure that individuals are not subjected to physical, verbal, sexual, or psychological abuse by anyone including but not limited to: facility staff...other individuals, or themselves." The policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs although sources of such support are available and offered and such failure results in physical or psychological harm to the individual." The policy and procedure indicated "...Neglect, includes failure to provide appropriate care, food, medical care, or supervision...." The policy indicated unknown injuries should be reported and thoroughly investigated.</p> <p>This federal tag relates to complaint #IN00195974.</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p>			

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	<p>Based on record review and interview, for 1 of 3 sampled clients (client A), the facility failed to accurately report client A's unknown bruises to BDDS (Bureau of Developmental Disabilities Services) in accordance with State Law.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and investigations from 12/1/2015 through 3/30/2016 were reviewed on 3/30/16 at 7:30pm and indicated no report which included client A had unknown bruises on his body.</p> <p>-A 3/10/16 BDDS report for an incident on 3/9/16 at 8:40am indicated "When the HM (House Manager) came into the group home the morning of 3/9/16 she noticed that [client A] appeared to be having a hard time breathing and there was a gurgling sound when he breathed." The report indicated the HM called 9-1-1, client A was transported by ambulance to the hospital, and was later placed on a ventilator. The report did not indicate client A had unknown bruises on his body.</p> <p>-A 3/24/16 Follow Up BDDS report to the incident on 3/9/16 at 8:40am indicated client A had been transferred</p>	W 0153	<p>Name and Address of Provider: McSherr, Inc., 496Denny Drive, New Castle, IN Date Survey Completed: 4/8/16 Provider Identification Number: 15G579 Survey Event ID: WHZW11 Finding: W153-The facility failed to accurately report client A's unknown bruises to BDDS(Bureau of Developmental Disabilities Services) in accordance with State Law.</p> <p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> ·Client A is now under the care of a hematologist ·High Risk Plan for Client A has been updated to address risk of bruising ·Social Services Coordinator, Residential Administrator, and Health Services Coordinator re-trained Denney Drive staff on completing Body Check form accurately and re-trained Denney Drive staff on BDDS Incident Reporting ·Lead Staff and/or House Manager will compare completed daily body checks to Accident and Injury Reports where bruises are documented to ensure compliance with reporting and investigating ·Staff that did not correctly complete Daily Body Check Form were counseled 	05/08/2016

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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>from Hospital #1 to Hospital #2 on 3/10/16 and his "liver enzymes were 700 and normal is 30-50." The report indicated client A's "liver problems were causing the blood issues...." The report indicated client A was taken off the ventilator on 3/14/16 and a "diagnosis that was given to [client A] was alter (sic) mental status, respiratory failure resolved, and Thrombocytopenia (a deficiency of platelets in the blood. This causes bleeding into the tissues, bruising, and slow blood clotting after injury) resolved." The report indicated client A was transferred back to the group home on 3/20/16. The report did not indicate client A had unknown bruises on his body.</p> <p>-A 2/28/16 BDDS report for an incident on 2/27/16 at 11:15am indicated client A "was shaking all over, appeared to be weak, and would not stand. He kept sitting on the floor stating that his legs didn't work." The report indicated after staff assisted him to sit on the sofa that client A "would not respond" to staff and client A was transported by ambulance to Hospital #1. The report indicated the hospital testing "didn't show anything definitely wrong...[The Doctor] was guessing at this point that it was a virus of some sort." The report did not indicate client A had unknown injuries and/or</p>		<ul style="list-style-type: none"> ·Allunknown bruises, even when discovered while hospitalized and attributed to an illness, will be reported to BDDS and APS and will be investigated per policy and regulations ·HealthServices Coordinator has added risk of bruising to Client A's High Risk Plan ·HealthServices Coordinator has added written guidelines for walking difficulties to Client A's High Risk Plan ·QuarterlyInterviews of staff and clients are reviewed by RA and at IDT to screen for potential abuse/neglect ·SocialServices Coordinator conducts quarterly interviews of ALL staff and ALL clients residing in McSherr Group Homes and asks specifically if there is anything that could be construed as abuse/neglect (such as bruising) that they would like to report ·Interviews are reviewed by RA and at IDT monthly to screen for potential abuse/neglect ·AllIA&I's and Incident Reports are now reviewed quarterly at a Professional Review Team meeting (includes QIDP, Residential Administrator, Social Services Coordinator, Health Services Coordinator, and one House Manager) to ensure that reporting and investigations are occurring as per policy, BDDS regulations and state law 				

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	<p>bruises on his body.</p> <p>On 3/31/16 at 8:00am, client A's 3/9/16 Hospital #1 "Discharge Summary" was reviewed. Hospital #1's Discharge Summary indicated "Hospital Course...Patient had previously also been complaining of overall weakness, vomiting and about 1 week prior had a fever as well as developing some bruising. However, for none of this was found out really why (sic)...Physical Examination...Skin shows several areas of ecchymosis (a discoloration of the skin resulting from bleeding underneath, typically caused by bruising) on his back as well as a new type of maybe some scabbing on his back. Areas of bruising that sometimes appear like handgrips on the side of the back of the leg. The staff said that this also occurred approximately 1 week ago. He had a follow up with a hematologist, but otherwise there was nothing found about it...."</p> <p>On 3/31/16 at 1:00pm, client A's 3/10/16 Hospital #2 "Social Work Progress Notes" indicated "Final Report...[Client A's name of Doctor] and [client A's] nurse reported having concerns about bruising on the patient's legs and hips that are (sic) in different stages of healing... [Name of Doctor] stated patient has low platelet count but no witness (sic)</p>		<p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All consumers have the potential to be affected. · Social Services Coordinator, Residential Administrator, and Health Services Coordinator re-trained Denney Drive staff on completing Body Check form daily and trained on BDDS Incident Reporting · Lead Staff and/or House Manager will compare completed daily body checks to Accident and Injury Reports where bruises are reported and investigated and reported to BDDS if unknown. · Staff that did not correctly complete Daily Body Check Form were counseled · All unknown bruises, even when discovered while hospitalized and attributed to an illness, will be reported to BDDS and APS and will be investigated per policy and regulations · Quarterly Interviews of staff and clients are reviewed by RA and at IDT to screen for potential abuse/neglect · Social Services Coordinator conducts quarterly interviews of ALL staff and ALL clients residing in McSherr Group Homes and asks specifically if there is anything that could potentially be construed as abuse/neglect (such 	

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	<p>seizures to explain bruising and recommended APS (Adult Protective Services) report."</p> <p>-Client A's 3/14/16 Hospital #2 "Case Management Notes" indicated client A had a legal guardian and client A's guardian had "shared...she was aware of bruising and shared that patient has been bruising easily over the past several weeks and has a hematology appointment schedule (sic) to investigate this further."</p> <p>-Client A's 3/10/16 Hospital #2 "Critical Care Progress Note" indicated client A had "Multiple bruises: Foot x-ray, no fracture...Integumentary (condition of the skin): Warm, dry, intact, excoriations/scratches along inner thighs bilaterally, Bruise on R (right) middle toe, Bruises along elbows and forearms bilaterally."</p> <p>-Client A's 3/10/16 Hospital #2 "Internal Med Resident Initial Consult" indicated client A was admitted from Hospital #1 and had "...Multiple bruises all over. XR (X-Ray) right foot third digit..."</p> <p>-Client A's 3/10/16 Hospital #2 "Nursing Assessment" indicated "...Bruising all over patient body with various stages of bruise (sic)...Bruising all over chest, arms, legs, and hips...."</p>		<p>as bruising) that theywould like to report</p> <ul style="list-style-type: none"> ·Interviewsare reviewed by RA and at IDT monthly to screen for potential abuse/neglect ·AllA&I's and Incident Reports are now reviewed quarterly at a ProfessionalReview Team meeting (includes QIDP, Residential Administrator, Social ServicesCoordinator, Health Services Coordinator, and one House Manager) to ensure thatreporting and investigations are occurring as per policy, BDDS regulations andstate law <p>Whatmeasures will be put into place or what systemic changes you will make toensure that the deficient practice does not recur?)</p> <ul style="list-style-type: none"> ·LeadStaff and/or House Manager will compare Daily Body Checks to Accident andInjury reports weekly to ensure all bruises and/or other injuries are documented and reported according to policy, BDDS regulations and state law. ·ALLincidents determined to be suspected abuse and/or neglect or suspicion of suchwill be investigated and reported to BDDS ·Allunknown bruises, even when discovered while hospitalized and attributed to anillness, will be reported to BDDS and APS and will be investigated per policy andregulations 	

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	<p>Client A's group home record was reviewed on 3/31/16 at 9:45am. Client A's "Daily Body Checks" indicated "Inspect the entire naked body at bath time each day. If a bruise, scratch, or other marks (sic) is found, place a number in the appropriate column...Place the same number on the body chart to indicate location. Detailed description (sic) need to be documented on the back of the sheet. All unknown injuries are to be reported immediately to the house manager." The "Daily Body Checks" form for the period from 3/1/16 through 3/21/16 indicated he did not have bruising or injuries to his skin.</p> <p>On 3/30/16 at 4:45pm, an interview with the House Manager (HM) was conducted. The HM stated when she came into the group home on 3/9/16, client A was in his bedroom, and his breathing "sounded like gurgling." The HM indicated client A needed two people to assist him so she and another staff helped dress client A, and "I saw bruises" on client A's body. The HM stated client A had "bruised easily" for several weeks. The HM indicated client A had no risk plan to address his bruising. The HM stated client A "had bruises under both arms" in his arm pits from staff assisting client A to walk, client A had "new" bruising on</p>		<ul style="list-style-type: none"> ·QuarterlyInterviews of staff and clients are reviewed by RA and at IDT to screen forpotential abuse/neglect ·SocialServices Coordinator conducts quarterly interviews of ALL staff and ALL clientsresiding at Denney Drive and asks specifically if there is anything that couldpotentially be construed as abuse/neglect (such as bruising) that they wouldlike to report ·Interviewsare reviewed by RA and at IDT monthly to screen for potential abuse/neglect ·AllA&I's and Incident Reports are now reviewed quarterly at a quarterlymeeting (includes QIDP, Residential Administrator, Social Services Coordinator,Health Services Coordinator, and one House Manager) to ensure that reportingand investigations are occurring as per policy, BDDS regulations and state law <p>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?</p> <ul style="list-style-type: none"> ·LeadStaff and/or House Manager will compare Daily Body Checks to Accident andInjury reports weekly to ensure all bruises and/or other injuries are documented and reported according to policy, BDDS 	

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	<p>his back, the top of his legs, and "I had not seen all those bruises on [client A's] legs." The HM indicated staff were to track all bruises and injuries on the daily skin sheets. The HM indicated an accident/injury report was to be filled out and an investigation would be initiated. The HM indicated she was unaware of any accident/injury report for these bruises.</p> <p>On 3/31/16 at 11:50am, an interview with the Residential Administrator (RA) was conducted. The RA indicated client A had experienced incidents in February, 2016 "when [client A] did not want to walk" and had dropped to his knees which could have caused some bruising. The RA indicated client A had an incident the end of February, 2016 that injured his right toe, client A had crawled on the floor, and had marks on his hands from the incident. The RA stated "all injuries of unknown origin" were reported and investigated. The RA indicated the agency reported the hospitalization for client A and the BDDS report did not indicate client A's unknown bruising. The RA indicated she witnessed client A's bruising when she was at the hospital with him on 3/9/16 at hospital #1 and again on 3/10/16 at hospital #2. The RA stated "it was like he was bruising as we looked at him"</p>		<p>regulations and state law.</p> <ul style="list-style-type: none"> ·ALL incidents determined to be suspected abuse and/or neglect or suspicion of such will be investigated and reported to BDDS ·All unknown bruises, even when discovered while hospitalized and attributed to an illness, will be reported to BDDS and APS and will be investigated per policy and regulations ·Social Services Coordinator currently interviews all clients and staff quarterly to determine if there is any suspected abuse or neglect that may be reportable ·Quarterly interviews are reviewed by the RA and team at monthly IDT meeting to screen for potential abuse/neglect <p>What is the date by which the systemic changes will be completed? 5/8/16</p> <p>Respectfully Submitted, Rosemary Taylor, Residential Administrator</p>	

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	<p>laying in the hospital bed.</p> <p>-The RA provided a 3/9/16 administrative summary narrative report which indicated "Morning of 3/9/16 RA was notified by HM that [client A] was being transported to hospital via ambulance after HM called 9-1-1 when breathing difficulty was noted. RA arrived at [name of Hospital #1] and saw HM sitting in hallway outside of nursing station in ER (Emergency Room)...HM stated that when she arrived at the home [client A] was still in his room in his bed. She tried talking to [client A] and he was attempting to talk but she could only understand one word. Within minutes she reports noticing breathing difficulties and heard a gurgling sound. HM decided at that time to call 9-1-1. [Client A] was transported to Emergency Room...Both RA and ER staff noted brownish bruises covering [client A's] body, chest, legs, etc... RA asked HM about the bruising and HM stated that she noticed some small bruises on Monday and an A&I (Accident & Injury report) was completed. She thought they may have been caused by staff assisting [client A] with ambulation since he had experienced difficulty after his ER visit the week before. HM stated that after IDT (Interdisciplinary Team) meeting on 3/8/16, she received a call from [client</p>			
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W 0154	<p>A's doctor] stating he wanted [client A] to see a Hematologist as some of his labs were abnormal."</p> <p>On 3/31/16 at 11:50am, the RA indicated client A's "Bruising was worse at the hospital," client A "was covered in bruises," and the bruising improved in one to two days. The RA indicated client A did not have a nursing protocol and no documentation was available for review of client A's bruises and unknown injuries. The RA indicated the facility followed the BDDS reporting policy to immediately report unknown injuries.</p> <p>On 3/31/16 at 11:13am, an interview with the Agency's Registered Nurse (RN) was conducted. The RN indicated client A's bruises from his previous injuries and unknown bruises were not recorded on client A's "Daily Skin Sheets" and should have been documented. The RN indicated the BDDS report documented client A's hospitalizations and did not report his unknown bruises.</p> <p>This federal tag relates to complaint #IN00195974.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS</p>			

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Bldg. 00	<p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview, for 1 of 3 sampled clients (client A), the facility failed to thoroughly investigate client A's unknown bruises.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and investigations from 12/1/2015 through 3/30/2016 were reviewed on 3/30/16 at 7:30pm and indicated no report which included client A had unknown bruises on his body.</p> <p>-A 3/10/16 BDDS report for an incident on 3/9/16 at 8:40am indicated "When the HM (House Manager) came into the group home the morning of 3/9/16 she noticed that [client A] appeared to be having a hard time breathing and there was a gurgling sound when he breathed." The report indicated the HM called 9-1-1, client A was transported by ambulance to the hospital, and was later placed on a ventilator. The report did not indicate client A had unknown bruises on his body.</p> <p>-A 3/24/16 Follow Up BDDS report to the incident on 3/9/16 at 8:40am</p>	W 0154	<p>Name and Address of Provider: McSherr, Inc., 496Denny Drive, New Castle, IN Date Survey Completed: 4/8/2016 Provider Identification Number: 15G579 Survey Event ID: WHZW11 Finding: W154 – The facility failed to thoroughly investigate client A's unknown bruises What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> · Client A's bruises have been investigated and determined to be caused by physician-diagnosed Thrombocytopenia · Client A is now under the care of a hematologist · High Risk Plan for Client A has been updated to address risk of bruising · Social Services Coordinator, Residential Administrator, and Health Services Coordinator re-trained Denney Drive staff on completing Body Check form daily and retrained Denney Drive staff on BDDS Incident Reporting · Lead Staff and/or House Manager will compare completed daily body checks to Accident and Injury Reports to ensure bruises are reported and investigated per policy and BDDS incident reporting guidelines · Staff that did not correctly complete Daily Body Check Form 	05/08/2016

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	<p>indicated client A had been transferred from Hospital #1 to Hospital #2 on 3/10/16 and his "liver enzymes were 700 and normal is 30-50." The report indicated client A's "liver problems were causing the blood issues...." The report indicated client A was taken off the ventilator on 3/14/16 and a "diagnosis that was given to [client A] was alter (sic) mental status, respiratory failure resolved, and Thrombocytopenia (a deficiency of platelets in the blood. This causes bleeding into the tissues, bruising, and slow blood clotting after injury) resolved." The report indicated client A was transferred back to the group home on 3/20/16. The report did not indicate client A had unknown bruises on his body.</p> <p>-A 2/28/16 BDDS report for an incident on 2/27/16 at 11:15am indicated client A "was shaking all over, appeared to be weak, and would not stand. He kept sitting on the floor stating that his legs didn't work." The report indicated after staff assisted him to sit on the sofa that client A "would not respond" to staff and client A was transported by ambulance to Hospital #1. The report indicated the hospital testing "didn't show anything definitely wrong...[The Doctor] was guessing at this point that it was a virus of some sort." The report did not indicate</p>		<p>were counseled</p> <ul style="list-style-type: none"> ·Allunknown bruises, even when discovered while hospitalized and attributed to anillness, will be reported to BDDS and APS and will be investigated per policyand regulations ·HealthServices Coordinator has added risk of bruising to Client A's High Risk Plan ·HealthServices Coordinator has added written guidelines for walking difficulties toClient A's High Risk Plan ·SocialServices Coordinator conducts quarterly interviews of ALL staff and ALL clientsresiding in McSherr Group Homes and asks specifically if there is anything thatcould potentially be construed as abuse/neglect (such as bruising) that theywould like to report ·Interviewsare reviewed by RA and team at monthly IDT to screen for potentialabuse/neglect ·AllA&I's and Incident Reports are now reviewed quarterly by QIDP, ResidentialAdministrator, Social Services Coordinator, Health Services Coordinator, andone House Manager to ensure that reporting and investigations are occurring asper policy, BDDS regulations and state law ·Allfuture unknown bruises will be reported and investigated per McSherr policy andBDDS incident reporting guidelines <p>Howwill you identify other</p>	

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	<p>client A had unknown injuries and/or bruises on his body.</p> <p>On 3/31/16 at 8:00am, client A's 3/9/16 Hospital #1 "Discharge Summary" was reviewed. Hospital #1's Discharge Summary indicated "Hospital Course...Patient had previously also been complaining of overall weakness, vomiting and about 1 week prior had a fever as well as developing some bruising. However, for none of this was found out really why (sic)...Physical Examination...Skin shows several areas of ecchymoses (a discoloration of the skin resulting from bleeding underneath, typically caused by bruising) on his back as well as a new type of maybe some scabbing on his back. Areas of bruising that sometimes appear like handgrips on the side of the back of the leg. The staff said that this also occurred approximately 1 week ago. He had a follow up with a hematologist, but otherwise there was nothing found about it...."</p> <p>On 3/31/16 at 1:00pm, client A's 3/10/16 Hospital #2 "Social Work Progress Notes" indicated "Final Report...[Client A's name of Doctor] and [client A's] nurse reported having concerns about bruising on the patient's legs and hips that are (sic) in different stages of healing... [Name of Doctor] stated patient has low</p>		<p>residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All consumers have the potential to be affected. ·Social Services Coordinator, Residential Administrator, and Health Services Coordinator re-trained Denney Drive staff on completing Body Check form daily and trained on BDDS Incident Reporting ·Lead Staff and/or House Manager will compare completed daily body checks to Accident and Injury Reports where bruises are reported and investigated and reported to BDDS if unknown. ·Staff that did not correctly complete Daily Body Check Form were counseled ·All unknown bruises, even when discovered while hospitalized and attributed to an illness, will be reported to BDDS and APS and will be investigated per policy and regulations ·Social Services Coordinator conducts quarterly interviews of ALL staff and ALL clients residing in McSherr Group Homes and asks specifically if there is anything that could potentially be construed as abuse/neglect (such as bruising) that they would like to report ·Interviews are reviewed by RA and team at monthly IDT to screen for potential abuse/neglect 				

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	<p>platelet count but no witness (sic) seizures to explain bruising and recommended APS (Adult Protective Services) report."</p> <p>-Client A's 3/14/16 Hospital #2 "Case Management Notes" indicated client A had a legal guardian and client A's guardian had "shared...she was aware of bruising and shared that patient has been bruising easily over the past several weeks and has a hematology appointment schedule (sic) to investigate this further." The report indicated "guardian has no concerns re (regarding): patient care at the group home."</p> <p>-Client A's 3/10/16 Hospital #2 "Critical Care Progress Note" indicated client A had "Multiple bruises: Foot x-ray, no fracture...Integumentary (condition of the skin): Warm, dry, intact, excoriations/scratches along inner thighs bilaterally, Bruise on R (right) middle toe, Bruises along elbows and forearms bilaterally."</p> <p>-Client A's 3/10/16 Hospital #2 "Internal Med Resident Initial Consult" indicated client A was admitted from Hospital #1 and had "...Multiple bruises all over. XR (X-Ray) right foot third digit...."</p> <p>-Client A's 3/10/16 Hospital #2 "Nursing</p>		<p>·All A&I's and Incident Reports are now reviewed quarterly by QIDP, Residential Administrator, Social Services Coordinator, Health Services Coordinator, and one House Manager to ensure reporting and investigations are occurring as per policy, BDDS regulations and state law</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?)</p> <p>·Lead Staff and/or House Manager will compare Daily Body Checks to Accident and Injury reports weekly to ensure all bruises and/or other injuries are documented and reported according to policy, BDDS Incident Reporting regulations and state law.</p> <p>·All incidents determined to be suspected abuse and/or neglect or suspicion of such will be investigated and reported to BDDS per McSherr policy, BDDS Incident Reporting guidelines, and state law</p> <p>·All unknown bruises, even when discovered while hospitalized and attributed to an illness, will be reported to BDDS and APS and will be investigated per policy and regulations</p> <p>·Social Services Coordinator conducts quarterly interviews of ALL staff and ALL clients residing at Denney Drive and asks</p>	

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	<p>Assessment" indicated "...Bruising all over patient body with various stages of bruise (sic)...Bruising all over chest, arms, legs, and hips...."</p> <p>Client A's group home record was reviewed on 3/31/16 at 9:45am. Client A's 3/21/16 ISP (Individual Support Plan), 3/2016 Risk Plans, and 3/2016 BSP (Behavior Support Plan) did not indicate client A was at risk for bruising. Client A's 11/13/15, 4/29/15, and 1/24/15 "Nursing Quarterly" assessments did not indicate client A was at risk for bruising, or had problems with bruising, or unknown injuries. Client A's "Daily Body Checks" indicated "Inspect the entire naked body at bath time each day. If a bruise, scratch, or other marks (sic) is found, place a number in the appropriate column...Place the same number on the body chart to indicate location. Detailed description (sic) need to be documented on the back of the sheet. All unknown injuries are to be reported immediately to the house manager." The "Daily Body Checks" form for the period from 3/1/16 through 3/21/16 indicated he did not have bruising or injuries to his skin.</p> <p>On 3/30/16 at 4:45pm, an interview with the House Manager (HM) was conducted. The HM stated when she came into the group home on 3/9/16, client A was in</p>		<p>specifically if there is anything that could potentially be construed as abuse/neglect (such as bruising) that they would like to report</p> <ul style="list-style-type: none"> · Interviews are reviewed by RA and team at monthly IDT to screen for potential abuse/neglect · All A&I's and Incident Reports are now reviewed quarterly at a quarterly meeting (includes QIDP, Residential Administrator, Social Services Coordinator, Health Services Coordinator, and one House Manager) to ensure that reporting and investigations are occurring as per policy, BDDS regulations and state law <p>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?</p> <ul style="list-style-type: none"> · Lead Staff and/or House Manager will compare Daily Body Checks to Accident and Injury reports weekly to ensure all bruises and/or other injuries are documented and reported according to policy, BDDS regulations and state law. · All incidents determined to be suspected abuse and/or neglect or suspicion of such will be investigated and reported to BDDS · All unknown bruises, even when discovered while hospitalized and attributed to an illness, will be reported to BDDS and APS and will be 	

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	<p>his bedroom, and his breathing "sounded like gurgling." The HM indicated client A needed two people to assist him, so she and another staff helped dress client A, and "I saw bruises" on client A's body. The HM stated client A had "bruised easily" for several weeks. The HM indicated client A had no risk plan to address his bruising. The HM stated client A "had bruises under both arms" in his arm pits from staff assisting client A to walk, client A had "new" bruising on his back, the top of his legs, and "I had not seen all those bruises on [client A's] legs." The HM indicated staff were to track all bruises and injuries on the daily skin sheets. The HM indicated an accident/injury report was to be filled out and an investigation would be initiated. The HM indicated she was unaware of any accident/injury report or investigation for these bruises.</p> <p>On 3/31/16 at 11:50am, an interview with the Residential Administrator (RA) was conducted. The RA indicated client A had experienced incidents in February, 2016 "when [client A] did not want to walk" and had dropped to his knees which could have caused some bruising. The RA indicated client A had an incident the end of February, 2016 that injured his right toe, client A had crawled on the floor, and had marks on his hands</p>		<p>investigated per policy and regulations</p> <ul style="list-style-type: none"> · Social Services Coordinator currently interviews all clients and staff quarterly to determine if there is any suspected abuse or neglect that may be reportable · Quarterly interviews are reviewed by the RA and IDT at monthly meeting to screen for potential abuse/neglect <p>What is the date by which the systemic changes will be completed? Respectfully Submitted, Rosemary Taylor, Residential Administrator</p>	

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	<p>from the incident. The RA stated "all injuries of unknown origin" were investigated. The RA indicated the agency reported the hospitalization for client A and the BDDS report did not indicate client A's unknown bruising. The RA indicated she witnessed client A's bruising when she was at the hospital with him on 3/9/16 at hospital #1 and again on 3/10/16 at hospital #2. The RA stated "it was like he was bruising as we looked at him" laying in the hospital bed.</p> <p>-The RA provided a 3/9/16 administrative summary narrative report which indicated "Morning of 3/9/16 RA was notified by HM that [client A] was being transported to hospital via ambulance after HM called 9-1-1 when breathing difficulty was noted. RA arrived at [name of Hospital #1] and saw HM sitting in hallway outside of nursing station in ER (Emergency Room)...HM stated that when she arrived at the home [client A] was still in his room in his bed. She tried talking to [client A] and he was attempting to talk but she could only understand one word. Within minutes she reports noticing breathing difficulties and heard a gurgling sound. HM decided at that time to call 9-1-1. [Client A] was transported to Emergency Room...Both RA and ER staff noted brownish bruises covering [client A's] body, chest, legs,</p>			
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	<p>etc... RA asked HM about the bruising and HM stated that she noticed some small bruises on Monday and an A&I (Accident & Injury report) was completed. She thought they may have been caused by staff assisting [client A] with ambulation since he had experienced difficulty after his ER visit the week before. HM stated that after IDT (Interdisciplinary Team) meeting on 3/8/16, she received a call from [client A's doctor] stating he wanted [client A] to see a Hematologist as some of his labs were abnormal."</p> <p>On 3/31/16 at 11:50am, the RA indicated client A's "Bruising was worse at the hospital," client A "was covered in bruises," and the bruising improved in one to two days. The RA indicated client A did not have a nursing protocol and no documentation was available for review of client A's bruises and unknown injuries. The RA indicated the facility followed the BDDS reporting and investigating policy to immediately report and to thoroughly investigate unknown injuries.</p> <p>On 3/31/16 at 11:13am, an interview with the Agency's Registered Nurse (RN) was conducted. The RN indicated he was unaware of any documented investigation regarding client A's unknown</p>			

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W 0331 Bldg. 00	<p>bruises/injuries.</p> <p>This federal tag relates to complaint #IN00195974.</p> <p>9-3-2(a)</p> <p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review, and interview, for 1 of 3 sampled clients (client A), the facility's nursing staff failed to develop guidelines for client A's bruising and changes in medical condition.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and investigations from 12/1/2015 through 3/30/2016 were reviewed on 3/30/16 at 7:30pm and indicated no report which included client A had unknown bruises on his body.</p> <p>-A 3/10/16 BDDS report for an incident on 3/9/16 at 8:40am indicated "When the HM (House Manager) came into the group home the morning of 3/9/16 she noticed that [client A] appeared to be having a hard time breathing and there was a gurgling sound when he breathed."</p>	W 0331	<p>Name and Address of Provider: McSherr, Inc., 496 Denney Drive, NewCastle, IN</p> <p>Date Survey Completed: 4/8/2016</p> <p>Provider Identification Number: 15G457</p> <p>Survey Event ID:WHZW11</p> <p>Finding: W331– the facility nursing services failed to develop guidelines for client A's bruising and changes in medical condition.</p> <p>What corrective action(s) will be accomplished for these residents found to have been affected by this finding?</p> <ul style="list-style-type: none"> ·Health Services Coordinator (HSC) has developed a protocol to alert staff to medical needs of client A if they arise again ·Health Services Coordinator has added risk of bruising to client A's High Risk Plan 	05/08/2016			

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	<p>The report indicated the HM called 9-1-1, client A was transported by ambulance to the hospital, and was later placed on a ventilator. The report did not indicate client A had unknown bruises on his body.</p> <p>-A 3/24/16 Follow Up BDDS report to the incident on 3/9/16 at 8:40am indicated client A had been transferred from Hospital #1 to Hospital #2 on 3/10/16 and his "liver enzymes were 700 and normal is 30-50." The report indicated client A's "liver problems were causing the blood issues...." The report indicated client A was taken off the ventilator on 3/14/16 and a "diagnosis that was given to [client A] was alter (sic) mental status, respiratory failure resolved, and Thrombocytopenia (a deficiency of platelets in the blood. This causes bleeding into the tissues, bruising, and slow blood clotting after injury) resolved." The report indicated client A was transferred back to the group home on 3/20/16. The report did not indicate client A had unknown bruises on his body.</p> <p>-A 2/28/16 BDDS report for an incident on 2/27/16 at 11:15am indicated client A "was shaking all over, appeared to be weak, and would not stand. He kept sitting on the floor stating that his legs</p>		<p>·HealthServices Coordinator has included written guidelines for staff to assist clientA with nursing care needs</p> <p>How will you identify other residents havingthe potential to be affected by the same deficient practice and what correctiveaction will be taken?</p> <p>·Allconsumers at high risk for bruising have the potential to be affected</p> <p>·HealthServices Coordinator (HSC) will develop a protocol to alert staff to medicalneeds of all clients at Denney Drive if and when need arises</p> <p>·HealthServices Coordinator will add risk of bruising to all Denney Drive client'sHigh Risk Plan if and when need arises</p> <p>·HealthServices Coordinator will include written guidelines for staff to assist DenneyDrive clients with nursing care if and when need arises</p> <p>Whatmeasures will be put into place or what systemic changes you will make toensure that the deficient practice does not recur?)</p> <p>·HealthServices Coordinator (HSC) will develop a protocol to alert staff to medicalneeds of all clients at Denney Drive if and when need arises</p> <p>·HealthServices Coordinator will add risk of bruising to all Denney Drive client'sHigh Risk Plan if and when need arises</p> <p>·HealthServices Coordinator will include written guidelines for staff</p>	

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	<p>didn't work." The report indicated after staff assisted him to sit on the sofa that client A "would not respond" to staff and client A was transported by ambulance to Hospital #1. The report indicated the hospital testing "didn't show anything definitely wrong...[The Doctor] was guessing at this point that it was a virus of some sort." The report did not indicate client A had unknown injuries and/or bruises on his body.</p> <p>On 3/31/16 at 8:00am, client A's 3/9/16 Hospital #1 "Discharge Summary" was reviewed. Hospital #1's Discharge Summary indicated "Hospital Course...Patient had previously also been complaining of overall weakness, vomiting and about 1 week prior had a fever as well as developing some bruising. However, for none of this was found out really why (sic) ...Physical Examination...Skin shows several areas of ecchymoses (a discoloration of the skin resulting from bleeding underneath, typically caused by bruising) on his back as well as a new type of maybe some scabbing on his back. Areas of bruising that sometimes appear like handgrips on the side of the back of the leg. The staff said that this also occurred approximately 1 week ago. He had a follow up with a hematologist, but otherwise there was nothing found about it...."</p>		<p>to assist DenneyDrive clients with nursing care if and when need arises</p> <p>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?</p> <ul style="list-style-type: none"> · HSC will monitor risk of bruising during quarterly nursing assessments · House Manager and/or designee will notify HSC of all incidents of bruising that are reportable · RA will monitor High Risk Plans to ensure risk of bruising is included as needed · Denney Drive staff have been retrained on completion of Daily Body Checks and appropriate supervisor notification <p>What is the date by which the systemic changes will be completed? 5/8/16</p> <p>Respectfully Submitted, Rosemary Taylor, Residential Administrator</p>				

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	<p>On 3/31/16 at 1:00pm, client A's 3/10/16 Hospital #2 "Social Work Progress Notes" indicated "Final Report...[Client A's name of Doctor] and [client A's] nurse reported having concerns about bruising on the patient's legs and hips that are (sic) in different stages of healing... [Name of Doctor] stated patient has low platelet count but no witness (sic) seizures to explain bruising and recommended APS (Adult Protective Services) report."</p> <p>-Client A's 3/14/16 Hospital #2 "Case Management Notes" indicated client A had a legal guardian and client A's guardian had "shared...she was aware of bruising and shared that patient has been bruising easily over the past several weeks and has a hematology appointment schedule (sic) to investigate this further." The report indicated "guardian has no concerns re (regarding): patient care at the group home."</p> <p>-Client A's 3/10/16 Hospital #2 "Critical Care Progress Note" indicated client A had "Multiple bruises: Foot x-ray, no fracture...Integumentary (condition of the skin): Warm, dry, intact, excoriations/scratches along inner thighs bilaterally, Bruise on R (right) middle toe, Bruises along elbows and forearms</p>			
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	<p>bilaterally."</p> <p>-Client A's 3/10/16 Hospital #2 "Internal Med Resident Initial Consult" indicated client A was admitted from Hospital #1 and had "...Multiple bruises all over. XR (X-Ray) right foot third digit...."</p> <p>-Client A's 3/10/16 Hospital #2 "Nursing Assessment" indicated "...Bruising all over patient body with various stages of bruise (sic)...Bruising all over chest, arms, legs, and hips...."</p> <p>Client A's group home record was reviewed on 3/31/16 at 9:45am. Client A's 3/21/16 ISP (Individual Support Plan), 3/2016 Risk Plans, and 3/2016 BSP (Behavior Support Plan) did not indicate client A was at risk for bruising. Client A's 11/13/15, 4/29/15, and 1/24/15 "Nursing Quarterly" assessments did not indicate client A was at risk for bruising, or had problems with bruising, or unknown injuries. Client A's "Daily Body Checks" indicated "Inspect the entire naked body at bath time each day. If a bruise, scratch, or other marks (sic) is found, place a number in the appropriate column...Place the same number on the body chart to indicate location. Detailed description (sic) need to be documented on the back of the sheet. All unknown injuries are to be reported immediately to</p>			

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	<p>the house manager." The "Daily Body Checks" form for the period from 3/1/16 through 3/21/16 indicated he did not have bruising or injuries to his skin.</p> <p>On 3/30/16 at 4:45pm, an interview with the House Manager (HM) was conducted. The HM stated when she came into the group home on 3/9/16, client A was in his bedroom, and his breathing "sounded like gurgling." The HM indicated client A needed two people to assist him, so she and another staff helped dress client A, and "I saw bruises" on client A's body. The HM stated client A had "bruised easily" for several weeks. The HM indicated client A had no risk plan to address his bruising. The HM stated client A "had bruises under both arms" in his arm pits from staff assisting client A to walk, client A had "new" bruising on his back, the top of his legs, and "I had not seen all those bruises on [client A's] legs." The HM indicated staff were to track all bruises and injuries on the daily skin sheets.</p> <p>On 3/31/16 at 11:50am, an interview with the Residential Administrator (RA) was conducted. The RA indicated client A had experienced incidents in February, 2016 "when [client A] did not want to walk" and had dropped to his knees which could have caused some bruising.</p>			

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	<p>The RA indicated client A had an incident the end of February, 2016 that injured his right toe, client A had crawled on the floor, and had marks on his hands from the incident. The RA stated "all injuries of unknown origin" were reported and investigated. The RA indicated the agency reported the hospitalization for client A and the BDDS report did not indicate client A's unknown bruising. The RA indicated she witnessed client A's bruising when she was at the hospital with him on 3/9/16 at hospital #1 and again on 3/10/16 at hospital #2. The RA stated "it was like he was bruising as we looked at him" laying in the hospital bed.</p> <p>-The RA provided a 3/9/16 administrative summary narrative report which indicated "Morning of 3/9/16 RA was notified by HM that [client A] was being transported to hospital via ambulance after HM called 9-1-1 when breathing difficulty was noted. RA arrived at [name of Hospital #1] and saw HM sitting in hallway outside of nursing station in ER (Emergency Room)...HM stated that when she arrived at the home [client A] was still in his room in his bed. She tried talking to [client A] and he was attempting to talk but she could only understand one word. Within minutes she reports noticing breathing difficulties</p>			

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	<p>and heard a gurgling sound. HM decided at that time to call 9-1-1. [Client A] was transported to Emergency Room...Both RA and ER staff noted brownish bruises covering [client A's] body, chest, legs, etc... RA asked HM about the bruising and HM stated that she noticed some small bruises on Monday and an A&I (Accident & Injury report) was completed. She thought they may have been caused by staff assisting [client A] with ambulation since he had experienced difficulty after his ER visit the week before. HM stated that after IDT (Interdisciplinary Team) meeting on 3/8/16, she received a call from [client A's doctor] stating he wanted [client A] to see a Hematologist as some of his labs were abnormal."</p> <p>On 3/31/16 at 11:50am, the RA indicated client A's "Bruising was worse at the hospital," client A "was covered in bruises," and the bruising improved in one to two days. The RA indicated client A did not have a nursing protocol and no documentation was available for review of client A's bruises and unknown injuries.</p> <p>On 3/31/16 at 11:13am, an interview with the Agency's Registered Nurse (RN) was conducted. The RN indicated client A's bruises from his previous injuries and</p>			

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W 0436 Bldg. 00	<p>unknown bruises were not recorded on client A's "Daily Skin Sheets" and should have been documented. The RN indicated the BDDS report documented client A's hospitalizations and did not report his unknown bruises. The RN indicated he was unaware of any documented investigation regarding client A's unknown bruises/injuries. The RN indicated client A did not have a nursing plan on how to assist client A when he was unable to walk independently. The RN indicated client A was able to walk independently with a walker before client A became ill. The RN indicated client A had no risk plan developed to address his skin problems related to his liver problems and to give staff written guidelines for assisting client A with his nursing care needs.</p> <p>This federal tag relates to complaint #IN00195974.</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.</p>			

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	<p>Based on observation, record review, and interview, for 1 of 3 sampled clients (client A) with adaptive equipment, the facility failed to teach and encourage client A to wear his prescribed eye glasses at the group home.</p> <p>Findings include:</p> <p>On 3/30/16 from 3:30pm until 5:30pm, client A were observed at the group home. During the observation period client A watched television, walked with staff assistance throughout the group home, consumed his snack, completed medication administration, and did not wear his prescribed eye glasses. Client A was not encouraged to wear his prescribed eye glasses.</p> <p>Client A's group home record was reviewed on 3/31/16 at 9:45am. Client A's 3/21/16 ISP (Individual Support Plan), 3/2016 Risk Plans, and 3/2016 BSP (Behavior Support Plan) indicated he wore prescribed eye glasses to see. Client A's 11/5/15 vision assessment indicated he wore prescribed eye glasses. Client A's 5/14/15 Fall risk plan did not include he wore prescribed eye glasses.</p> <p>On 3/31/16 at 11:13am, an interview with the Agency's Registered Nurse (RN) was conducted. The RN indicated client A</p>	W 0436	<p>Name and Address of Provider: McSherr, Inc., 496 Denney Drive, NewCastle, IN</p> <p>Date Survey Completed: 4/8/2016</p> <p>Provider Identification Number: 15G457</p> <p>Survey Event ID: WHZW11</p> <p>Finding: W436—The facility failed to teach and encourage client A to wear his prescribed eye glasses at the group home</p> <p>What corrective action(s) will be accomplished for these residents found to have been affected by this finding? ·Client A now has a written plan to formally and informally (implemented on 4/11/16) teach and encourage client A to wear his prescribed eye glasses at the group home both</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? ·All consumers at Denney Drive that have eye glasses have the potential to be affected ·All consumers at Denney Drive that have eye glasses will have a written plan to formally and informally teach and encourage them to wear eyeglasses</p> <p>What measures will be put into</p>	05/08/2016

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	wore prescribed eye glasses. The RN indicated client A should have been taught and encouraged to wear his prescribed eye glasses during formal and informal opportunities. 9-3-7(a)		<p>place or what systemic changes you will make to ensure that the deficient practice does not recur?)</p> <ul style="list-style-type: none"> ·Written plans for Denney Drive clients that wear eyeglasses will formally and informally teach and encourage clients to wear eyeglasses ·Denney Drive staff will offer eye glasses to consumers that wear eyeglasses during formal and informal training opportunities ·Denney Drive staff will document that they have encouraged clients to wear eyeglasses during formal and informal training opportunities <p>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?</p> <ul style="list-style-type: none"> ·Denney Drive staff daily notes will document formal and informal training opportunities where Denney Drive consumers that wear eyeglasses are trained and encouraged to wear glasses ·A monitoring sheet for Denney Drive consumers that wear eyeglasses may be implemented if refusals are negatively impacting health and safety ·House Manager, Social Services Coordinator, QIDP, Health Services Coordinator, and Residential Administrator will monitor for compliance with formal and informal training opportunities when completing 	

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			<p>observations in the home.</p> <p>What is the date by which the systemic changes will be completed? 5/8/16</p> <p>Respectfully Submitted, Rosemary Taylor, Residential Administrator</p>	