

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/29/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST	STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: September 17, 18, 19, 22, 23 and 29, 2014.</p> <p>Facility Number: 000971 Provider Number: 15G457 AIMS Number: 100244800</p> <p>Surveyor: Vickie Kolb, RN</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/8/14 by Ruth Shackelford, QIDP.</p>	W000000		
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 observation, record review and interview for 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 4 additional clients (#5, #6, #7 and #8), the facility neglected to implement its policy and procedures to ensure: __All allegations of neglect were immediately reported to the administrator and to BDDS (Bureau of Developmental</p>	W000149	<p>Name and Address of Provider: McSherr, Inc., 4412 So. B. Street, Richmond, IN Date Survey Completed: 9/29/2014 Provider Identification Number: 15G457 Survey Event ID: ZXU211 Finding: W149 – The facility neglected to implement its policy and procedures to ensure: __All allegations of neglect were immediately reported to the</p>	10/27/2014

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2014	
NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST				STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law for clients #1, #2, #3, #4, #5, #6 and #7.</p> <p>__The investigation of neglect included a specific plan of corrective oversight to include how the facility staff would be monitored to prevent reoccurrence in regard to neglect and staff sleeping while on duty for all clients living at the group home (#1, #2, #3, #4, #5, #6, #7 and #8).</p> <p>Findings include:</p> <p>The facility's reportable and investigative records were reviewed on 9/17/14 at 3:30 PM.</p> <p>The 2/12/14 BDDS report indicated on 2/12/14 it was reported to the SW (Social Worker) that staff #10 had slept while working the overnight shift at the home of clients #1, #2, #3, #4, #5, #6, #7 and #8. "Although there was another staff member awake during this time, sleeping during work hours can be considered neglect of the residents. An internal investigation into this allegation was started by the SSD (Social Services Director) on 2/12/14. [Staff #10] was suspended on 2/12/14 until the investigation is completed."</p> <p>The 2/19/14 BDDS follow up report</p>		<p>administrator and toBDDS(Bureau of DevelopmentalDisabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services)per IC 12-10-3 according to state law for clients #1, #2, #3, #4, #5, #6 and#7.</p> <p>__The investigation of neglect included aspecific plan of corrective oversight to include how the facility staff wouldbe monitored to prevent reoccurrence in regard to neglect and staff sleepingwhile on duty for all clients living at the group home (#1, #2, #3, #4, #5, #6,#7 and #8). Whatcorrective action(s) will be accomplished for these residents found to havebeen affected by the deficient practice?</p> <ul style="list-style-type: none"> ·Allallegations of neglect, including allegations of sleeping while on duty, willbe immediately reported to the administrator, BDDS, and APS per regulations,state law, and McSherr policy ·Allinvestigations of neglect, including allegations of sleeping while on duty, will include a specific plan ofcorrective oversight that will include how McSherr staff will be monitored toprevent recurrence ·IDT will review observation logsmonthly to assure House Manager unscheduled night visits are completed ·All staff are required to completehourly checks for 				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/29/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST	STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>indicated the internal investigation into the allegation of neglect reported on 2/12/14 was completed on 2/14/14. The results of the investigation indicated the allegation was substantiated. "The investigation consisted of interviewing 6 McSherr staff members and 4 McSherr residents. When McSherr's SW interviewed the staff, the questions were: 1) Do you have a concern with any of your co-workers sleeping on the job? 2) Do you have a concern with any of your co-workers being neglectful to the residents or to their job duties?</p> <p>__Staff 1: Stated 'Yes, it is getting out of hand.' to question 1. She (Staff 1) stated that she had worked with [staff #10] one night and she (staff #10) had went (sic) to sleep roughly around 10:30 pm and slept for a few hours. Staff 1 stated 'yes, they are sitting at the table talking with each other and not doing any work on Sat. (Saturday) and Sun. (Sunday) mornings when 3rd shift leave.'</p> <p>__Staff 2: Stated 'Yes, I do, [staff #10]' to question 1. She (Staff 2) went on to state that when working a 12 hour shift on a Saturday with [staff #10], that [staff #10] had slept and she (Staff 2) had to wake her up and that she (staff #10) did not even do her books.' To question 2, Staff 2 stated 'Not anyone I work with.'</p> <p>__Staff 3: Stated she (Staff 3) only works the 12 hour shift every Sat. For question</p>		<p>assigned consumers on every night shift</p> <ul style="list-style-type: none"> ·Staff will document on tracking sheet that hourly check has been completed ·House Manager will review daily or within 72 hours on the weekend, to ensure staff completed hourly checks ·McSherr is contacting Accel (provider of electronic record keeping) to see if hourly checks can be date and timestamped for each staff assuring they are awake and caring for consumers ·Social Services Coordinator will contact each consumer at South B Street in person and each South B Street employee through Accel every 30 days to ask if any staff have been observed or if he/she has been told any staff have been sleeping while at work This will continue for 6 months then will be done on a quarterly basis after 6 months <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. ·All allegations of neglect, including allegations of sleeping while on duty, will be immediately reported to the administrator, BDDS, and APS per regulations, state law, and McSherr policy ·All investigations of neglect, 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2014
NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST			STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>1 Staff 3 stated she worked with [staff #10] her 1st Sat. that she (Staff 3) worked. According to Staff 3 [staff #10] slept in a chair in the 2nd living room. Staff 3 stated that she (Staff 3) and her other co-workers tried to wake [staff #10] up several times. [Staff #10] had stated her back hurt and her mother came by and dropped off some muscle relaxants. According to Staff 3 after taking the medication, [staff #10] slept off and one (sic) all day while working. She (staff #10) only did her showers. To question 2 Staff 3 stated 'No, everybody I usually work with pull their weight.'</p> <p>__Staff 4: stated 'Yes' to question 1. She (Staff 4) stated that she worked with [staff #10] on a Saturday and [staff #10] 'slept pretty much all day.' Staff 4 stated she and the other staff tried to get her (staff #10) up several times. To question 2 staff 4 stated 'yes and no.' She stated when smokers go out and smoked every hour this could be neglectful to the residents.</p> <p>__Staff 5: stated 'On 2/11/14 I was working with [staff #10] and she only mopped the hallway and at 1:10 am she (staff #10) laid down on the loveseat with the lights out and stated she had her alarm set for every 20 minutes.'</p> <p>According to Staff 5, [staff #10] did not get up until 5:45 am. Later she (staff #10) had stated to staff 5 'You almost got me</p>		<p>including allegations of sleeping while on duty, will include a specific plan of corrective oversight that will include how McSherr staff will be monitored to prevent recurrence</p> <ul style="list-style-type: none"> · IDT will review observation logs monthly to assure unscheduled night visits are completed · Residential Administrator will sign off on observation logs each month when visits are completed · All staff are required to complete hourly checks for assigned consumers on every night shift · Staff will document on tracking sheet that hourly check has been completed · House Manager will review daily or within 72 hours on the weekend, to ensure staff completed hourly checks · McSherr is contacting Accel (provider of electronic record keeping) to see if hourly checks can be date and timestamped for each staff assuring they are awake and caring for consumers · Social Services Coordinator will contact each consumer at South B Street in person and each South B Street employee through Accel every 30 days to ask if any staff have been observed or if he/she has been told any staff have been sleeping while at work This will continue for 6 months then will be done on a quarterly basis after 6 months <p>What measures will be put into place or what systemic</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2014
NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST			STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>caught' due to the HM (House Manager) coming into the group home right after she had gotten up.</p> <p>__ Staff 6: stated to question 1 that [staff #10] had slept for about 4 hours on a Sunday 3rd shift with her. [Staff #10] woke up herself before the residents got up for the day. To question 2, staff 6 stated she has concerns with some of her co-workers not assisting in morning activities with staff.... The investigation results showed that the allegation was substantiated due to all 6 staff that was interviewed stating [staff #10] had slept during her work hours whether it was a 3rd shift or a weekend 12 hour shift. [Staff #10] was terminated on 2/14/14."</p> <p>The 2/14/14 BDDS report indicated on 2/8/14 "McSherr's SW was made aware of an allegation of neglect on 2/13/14, which stated that [staff #11] was sleeping during her 3rd shifts, at the [address of the facility] group home. McSherr's SW was made aware of this while conducting another investigation. [Staff #11] was suspended on 2/13/14 while the SW conducted an investigation into this allegation. The investigation was completed on 2/14/14. The results of the investigation indicated that the allegation was unsubstantiated. The investigation consisted of interviewing the 2 staff members that work with [staff #11] and 4</p>		<p>changes you will make toensure that the deficient practice does not recur?)</p> <ul style="list-style-type: none"> ·SocialServices Coordinator will interview consumers and staff quarterly (ie. March,June, September, and December) and ask if there are any concerns with co-workers,peers, etc to be proactive Results obtained and possible solutions willbe discussed at the next scheduled IDT. ·HouseManagers will complete one unscheduled night visit each month ·ResidentialAdministrator will sign off on observation logs each month after night visitsare completed ·All staff are required to completehourly checks for assigned consumers on every night shift ·Staff will document on tracking sheetthat hourly check has been completed ·House Manager will review daily orwithin 72 hours on the weekend, to ensure staff completed hourly checks ·McSherr is contacting Accel (providerof electronic record keeping) to see if hourly checks can be date and timestamped for each staff assuring they are awake and caring for consumers ·Social Services Coordinator will contact each consumer at South B Street in person and each South B Street employee through Accel every 30 days to 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/29/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST	STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>McSherr Residents.... Staff 2 stated that [staff #11] may doze 10 minutes during her shift, but does not sleep hours. The results of the investigation showed that the allegation was not substantiated due to not enough facts/evidence to prove [staff #11] is sleeping for 8 to 10 hours during her shift. [Staff #11] was taken off of suspension on 2/14/14. She (staff #11) will be re-trained on what Neglect is and McSherr's policy concerning sleeping on the job. This training is scheduled for 2/18/14."</p> <p>The 3/5/14 follow up BDDS report indicated "The results of the investigation into [staff #11] sleeping during her 3rd shift indicated that the allegation of her sleeping 8 to 10 hours was unsubstantiated. When the staff member that originally reported this allegation was asked on 2/13/14 'Did you ever feel like co-workers sleeping were neglecting the residents' she stated 'No never felt like co-workers sleeping was neglecting residents because I take care of all 8 (clients).' The morning of 2/14/14, this staff member (staff 1) called and stated that she was going to 'take back what she said.' When the SSD asked her what she meant staff 1 stated 'it's a lie.' When staff 1 was asked if she was stating that her original report was a lie, she stated, 'Well McSherr always takes what the residents</p>		<p>ask if any staff have been observed or if he/she has been told any staff have been sleeping while at work This will continue for 6 months then will be done on a quarterly basis after 6 months 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"> ·ResidentialAdministrator will monitor through review of observation logs ·SocialServices Coordinator will monitor through quarterly interview of consumers and staffto determine if there are any deficiencies in services, including neglect ·ResidentialAdministrator will review all investigations to ensure that corrective actions includeoversight of staff. ·House Manager will review daily orwithin 72 hours on the weekend, to ensure staff completed hourly checks ·McSherr is contacting Accel (providerof electronic record keeping) to see if hourly checks can be date and timestamped for each staff assuring they are awake and caring for consumers ·Social Services Coordinator will contact each consumer at South B Street in person and each South B Street employee through Accel every 30 days to ask if any staff have been observed or if he/she has been 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2014	
NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST				STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>say over the staff.' The SSD explained to Staff 1 that during an investigation everything is looked at. At the end of the conversation, the SSD asked staff 1 if she still wanted to take back what she had originally reported, and staff 1 said 'No, I can't do it because it wouldn't be right.'</p> <p>The investigation did not turn up enough evidence to prove the original allegation. Staff 1 changed her report twice, staff 2 indicated she may doze, the 4 residents stated they had never seen a staff member sleep, and [staff #11] denied sleeping. McSherr did a training on 2/20/14 with every staff who works at the [address of facility] group home, including [staff #11], on McSherr's policy of sleeping on the job. The staff was trained at this time that any form of sleeping on the job will not be tolerated and will be considered neglect. It was also stated at the training that any staff working with another staff that is sleeping will be just as guilty if they do not try to wake up their co-worker or do not report it to their manager."</p> <p>Review of the monthly observation checklists for the clients living in the group home (clients #1, #2, #3, #4, #5, #6, #7 and #8) from February 2014 to August 2014 on 9/23/14 at 2 PM indicated no unscheduled visits by administrative staff to the group home for</p>		<p>told any staff have been sleeping while at work This will continue for 6 months then will be done on a quarterly basis after 6 months</p> <p>Whatis the date by which the systemic changes will be completed? 10/27/2014</p> <p>RespectfullySubmitted, RosemaryTaylor, Residential Administrator</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2014	
NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST				STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>the night shift were made in May and/or July 2014.</p> <p>The facility records indicated no specific plan of corrective oversight and/or how the facility staff would be monitored to prevent the neglect in regard to staff sleeping from reoccurrence. The facility records indicated no documentation of administrative and/or supervisory staff observations and/or monitoring.</p> <p>During interview with the RD (Residential Director) on 9/17/14 at 2 PM, the RD indicated all allegations of neglect were to be reported immediately to the administrator and to BDDS and APS (Adult Protective Services) within 24 hours of the time of knowledge of the neglect.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) and the SSD on 9/23/14 at 3 PM indicated staff sleeping on duty was considered neglect of the clients and the staff were to report this immediately to the administrator. When asked if the investigative summary included how the facility would monitor the staff to ensure the clients were not being neglected due to staff sleeping, the SSD stated, "We retrained the staff on neglect and I think [name of home manager] does monthly</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/29/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST	STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>drop in visits." The SSD indicated the drop in visits were not something new and to her knowledge the home managers had always done unscheduled drop in visits once a month just to see how things were going in the group home. The SSD indicated the investigative summary did not include a plan of corrective oversight of how the facility would monitor the staff to ensure clients were not being neglected due to staff sleeping while on duty.</p> <p>Review of the undated revised facility policy "MCSHERR, INC. INVESTIGATIONS and SUSPECTED ABUSE NEGLECT OR EXPLOITATION" on 8/4/14 at 1 PM indicated, but not all inclusive: ___ "All McSherr employees are required to report any alleged, suspected or known abuse, neglect, or exploitation of an individual; a violation of rights; client to client abuse; and all injures of unknown origin to there supervisor immediately. In the case of a client in Group Homes, the House Manager will be notified immediately. House Manager will then notify the Social Worker." ___ "Any alleged, suspected, or actual abuse, neglect or exploitation of an individual, any violation of an individual's rights, any client to client abuse, and/or any injuries of unknown</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2014
NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST			STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W000153	<p>origin must be reported accordingly to Bureau of Quality Improvement Services (BQIS) within twenty-four (24) hours, while following appropriate reporting procedures."</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. Based on record review and interview for 1 of 2 allegations of abuse/neglect reviewed, the facility failed to immediately report all allegations of neglect to the administrator and to the BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law for clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>Findings include:</p> <p>The facility's reportable and investigative records were reviewed on 9/17/14 at 3:30 PM.</p>	W000153	<p>Name and Address of Provider: McSherr, Inc., 4412 So. B. Street, Richmond, IN Date Survey Completed: 9/29/2014 Provider Identification Number: 15G457 Survey Event ID: ZXU211 Finding: W153 – the facility failed to immediately report all allegations of neglect to the administrator and to the BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law for clients #1, #2, #3, #4, #5, #6, #7 and #8. What corrective action(s) will be accomplished for these residents found to have been affected by the</p>	10/27/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2014	
NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST				STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>The 2/12/14 BDDS report indicated on 2/12/14 it was reported to the SW (Social Worker) that staff #10 had slept while working the overnight shift at the home of clients #1, #2, #3, #4, #5, #6, #7 and #8. "Although there was another staff member awake during this time, sleeping during work hours can be considered neglect of the residents. An internal investigation into this allegation was started by the SSD (Social Services Director) on 2/12/14. [Staff #10] was suspended on 2/12/14 until the investigation is completed."</p> <p>The 2/19/14 BDDS follow up report indicated the internal investigation into the allegation of neglect reported on 2/12/14 was completed on 2/14/14. The results of the investigation indicated the allegation was substantiated. "The investigation consisted of interviewing 6 McSherr staff members and 4 McSherr residents. When McSherr's SW interviewed the staff, the questions were: 1) Do you have a concern with any of your co-workers sleeping on the job? 2) Do you have a concern with any of your co-workers being neglectful to the residents or to their job duties? __ Staff 1: Stated 'Yes, it is getting out of hand.' to question 1. She (Staff 1) stated that she had worked with [staff #10] one night and she (staff #10) had went (sic) to</p>		<p>deficient practice?</p> <ul style="list-style-type: none"> ·All allegations of neglect, including allegations of sleeping while on duty, will be immediately reported to the administrator, BDDS, and APS per regulations, state law, and McSherr policy ·All investigations of neglect, including allegations of sleeping while on duty, will include a specific plan of corrective oversight that will include how McSherr staff will be monitored to prevent recurrence ·IDT will review observation logs monthly to assure unscheduled night visits are completed ·All staff are required to complete hourly checks for assigned consumers on every night shift ·Staff will document on tracking sheet that hourly check has been completed ·House Manager will review daily or within 72 hours on the weekend, to ensure staff completed hourly checks ·McSherr is contacting Accel (provider of electronic record keeping) to see if hourly checks can be date and time stamped for each staff assuring they are awake and caring for consumers ·Failure to report allegations of suspected neglect in a timely manner will result in staff discipline per McSherr policy, state and federal regulations and the law. ·Social Services Coordinator 				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2014	
NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST				STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>sleep roughly around 10:30 pm and slept for a few hours. Staff 1 stated 'yes, they are sitting at the table talking with each other and not doing any work on Sat. (Saturday) and Sun. (Sunday) mornings when 3rd shift leave.'</p> <p>__ Staff 2: Stated 'Yes, I do, [staff #10]' to question 1. She (Staff 2) went on to state that when working a 12 hour shift on a Saturday with [staff #10], that [staff #10] had slept and she (Staff 2) had to wake her up and that she (staff #10) did not even do her books.' To question 2, Staff 2 stated 'Not anyone I work with.'</p> <p>__ Staff 3: Stated she (Staff 3) only works the 12 hour shift every Sat. For question 1 Staff 3 stated she worked with [staff #10] her 1st Sat. that she (Staff 3) worked. According to Staff 3 [staff #10] slept in a chair in the 2nd living room. Staff 3 stated that she (Staff 3) and her other co-workers tried to wake [staff #10] up several times. [Staff #10] had stated her back hurt and her mother came by and dropped off some muscle relaxants. According to Staff 3 after taking the medication, [staff #10] slept off and one (sic) all day while working. She (staff #10) only did her showers. To question 2 Staff 3 stated 'No, everybody I usually work with pull their weight.'</p> <p>__ Staff 4: stated 'Yes' to question 1. She (Staff 4) stated that she worked with [staff #10] on a Saturday and [staff #10]</p>		<p>will contact each consumer at South B Street in person and each South B Street employee through Accel every 30 days to ask if any staff have been observed or if he/she has been told any staff have been sleeping while at work This will continue for 6 months then will be done on a quarterly basis after 6 months</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. ·Allegations of neglect, including allegations of sleeping while on duty, will be immediately reported to the administrator, BDDS, and APS per regulations, state law, and McSherr policy ·All investigations of neglect, including allegations of sleeping while on duty, will include a specific plan of corrective oversight that will include how McSherr staff will be monitored to prevent recurrence ·IDT will review observation logs monthly to assure unscheduled night visits are completed ·Residential Administrator will sign off on observation logs each month when visits are completed ·All staff are required to complete hourly checks for assigned consumers on every night shift 				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2014	
NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST				STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>'slept pretty much all day.' Staff 4 stated she and the other staff tried to get her (staff #10) up several times. To question 2 staff 4 stated 'yes and no.' She stated when smokers go out and smoked every hour this could be neglectful to the residents.</p> <p>__Staff 5: stated 'On 2/11/14 I was working with [staff #10] and she only mopped the hallway and at 1:10 am she (staff #10) laid down on the loveseat with the lights out and stated she had her alarm set for every 20 minutes.'</p> <p>According to Staff 5, [staff #10] did not get up until 5:45 am. Later she (staff #10) had stated to staff 5 'You almost got me caught' due to the HM (House Manager) coming into the group home right after she had gotten up.</p> <p>__Staff 6: stated to question 1 that [staff #10] had slept for about 4 hours on a Sunday 3rd shift with her. [Staff #10] woke up herself before the residents got up for the day. To question 2, staff 6 stated she has concerns with some of her co-workers not assisting in morning activities with staff.... The investigation results showed that the allegation was substantiated due to all 6 staff that was interviewed stating [staff #10] had slept during her work hours whether it was a 3rd shift or a weekend 12 hour shift. [Staff #10] was terminated on 2/14/14."</p>		<ul style="list-style-type: none"> ·Staff will document on tracking sheet that hourly check has been completed ·Failure to report allegations of suspected neglect in a timely manner will result in staff discipline per McSherr policy, state and federal regulations and the law. ·House Manager will review daily or within 72 hours on the weekend, to ensure staff completed hourly checks ·McSherr is contacting Accel (provider of electronic record keeping) to see if hourly checks can be date and timestamped for each staff assuring they are awake and caring for consumers ·Social Services Coordinator will contact each consumer at South B Street in person and each South B Street employee through Accel every 30 days to ask if any staff have been observed or if he/she has been told any staff have been sleeping while at work This will continue for 6 months then will be done on a quarterly basis after 6 months What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?) ·Social Services Coordinator will interview consumers and staff quarterly (ie. March, June, September, and December) and ask if there are any concerns with co-workers, peers, etc to be proactive. Results obtained and 				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2014	
NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST				STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>The 2/14/14 BDDS report indicated on 2/8/14 "McSherr's SW was made aware of an allegation of neglect on 2/13/14, which stated that [staff #11] was sleeping during her 3rd shifts, at the [address of the facility] group home. McSherr's SW was made aware of this while conducting another investigation.... Staff 2 stated that [staff #11] may doze 10 minutes during her shift, but does not sleep hours.... She (staff #11) will be re-trained on what Neglect is and McSherr's policy concerning sleeping on the job."</p> <p>The 3/5/14 follow up BDDS report indicated "The results of the investigation into [staff #11] sleeping during her 3rd shift indicated that the allegation of her sleeping 8 to 10 hours was unsubstantiated. When the staff member that originally reported this allegation was asked on 2/13/14 'Did you ever feel like co-workers sleeping were neglecting the residents' she stated 'No never felt like co-workers sleeping was neglecting residents because I take care of all 8 (clients).' The morning of 2/14/14, this staff member (staff 1) called and stated that she was going to 'take back what she said.' When the SSD asked her what she meant staff 1 stated 'it's a lie.' When staff 1 was asked if she was stating that her original report was a lie, she stated, 'Well McSherr always takes what the residents</p>		<p>possible solutions will be discussed at the next scheduled IDT.</p> <ul style="list-style-type: none"> ·House Managers will complete one unscheduled night visit each month ·Residential Administrator will sign off on observation logs each month after night visits are completed ·Failure to report allegations of suspected neglect in a timely manner will result in staff discipline perMcSherr policy, state and federal regulations and the law. ·Social Services Coordinator will contact each consumer at South B Street in person and each South B Street employee through Accel every 30 days to ask if any staff have been observed or if he/she has been told any staff have been sleeping while at work This will continue for 6 months then will be done on a quarterly basis after 6 months <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"> ·Residential Administrator will monitor through review of observation logs ·Social Services Coordinator will monitor through quarterly interview of consumers and staff to determine if there are any deficiencies in services, including neglect and failure to report 				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/29/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST	STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>say over the staff.' The SSD explained to Staff 1 that during an investigation everything is looked at. At the end of the conversation, the SSD asked staff 1 if she still wanted to take back what she had originally reported, and staff 1 said 'No, I can't do it because it wouldn't be right.'</p> <p>The investigation did not turn up enough evidence to prove the original allegation. Staff 1 changed her report twice, staff 2 indicated she may doze, the 4 residents stated they had never seen a staff member sleep, and [staff #11] denied sleeping. McSherr did a training on 2/20/14 with every staff who works at the [address of facility] group home, including [staff #11], on McSherr's policy of sleeping on the job. The staff was trained at this time that any form of sleeping on the job will not be tolerated and will be considered neglect. It was also stated at the training that any staff working with another staff that is sleeping will be just as guilty if they do not try to wake up their co-worker or do not report it to their manager."</p> <p>During interview with the RD (Residential Director) on 9/17/14 at 2 PM, the RD indicated all allegations of neglect were to be reported immediately to the administrator and to BDDS and APS (Adult Protective Services) within 24 hours of the time of knowledge of the</p>		<p>·Residential Administrator will review all investigations to ensure that corrective actions include monitoring of staff</p> <p>·Social Services Coordinator will contact each consumer at South B Street in person and each South B Street employee through Accel every 30 days to ask if any staff have been observed or if he/she has been told any staff have been sleeping while at work This will continue for 6 months then will be done on a quarterly basis after 6 months</p> <p>What is the date by which the systemic changes will be completed? 10/27/2014</p> <p>Respectfully Submitted, Rosemary Taylor, Residential Administrator</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/29/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST	STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000157	<p>neglect.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) and the SSD on 9/23/14 at 3 PM indicated staff sleeping on duty was considered neglect of the clients and the staff were to report this immediately to the administrator.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on interview and record review for 1 of 2 allegations of abuse/neglect reviewed, the facility failed to ensure the investigation of the neglect included a specific plan of corrective oversight to include how the facility staff would be monitored to prevent reoccurrence in regard to neglect and staff sleeping while on duty for all clients living at the group home (clients #1, #2, #3, #4, #5, #6, #7 and #8).</p> <p>Findings include:</p> <p>The facility's reportable and investigative records were reviewed on 9/17/14 at 3:30</p>	W000157	<p>Name and Address of Provider: McSherr, Inc., 4412 So. B. Street, Richmond, IN Date Survey Completed: 9/29/2014 Provider Identification Number: 15G457 Survey Event ID: ZXU211 Finding: W157 – The facility failed to ensure the investigation of the neglect included a specific plan of corrective oversight to include how the facility staff would be monitored to prevent reoccurrence in regard to neglect and staff sleeping while on duty for all clients living at the group home (clients #1, #2, #3, #4, #5, #6, #7 and #8). What corrective action(s) will be accomplished for these residents found to</p>	10/27/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2014
NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST			STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>PM.</p> <p>The 2/12/14 BDDS report indicated on 2/12/14 it was reported to the SW (Social Worker) that staff #10 had slept while working the overnight shift at the home of clients #1, #2, #3, #4, #5, #6, #7 and #8. "Although there was another staff member awake during this time, sleeping during work hours can be considered neglect of the residents. An internal investigation into this allegation was started by the SSD (Social Services Director) on 2/12/14. [Staff #10] was suspended on 2/12/14 until the investigation is completed."</p> <p>The 2/19/14 BDDS follow up report indicated the internal investigation into the allegation of neglect reported on 2/12/14 was completed on 2/14/14. The results of the investigation indicated the allegation was substantiated. "The investigation consisted of interviewing 6 McSherr staff members and 4 McSherr residents. When McSherr's SW interviewed the staff, the questions were: 1) Do you have a concern with any of your co-workers sleeping on the job? 2) Do you have a concern with any of your co-workers being neglectful to the residents or to their job duties? __Staff 1: Stated 'Yes, it is getting out of hand.' to question 1. She (Staff 1) stated</p>		<p>have been affected by the deficient practice?</p> <ul style="list-style-type: none"> · All investigations of neglect, including allegations of sleeping while on duty, will include a specific plan of corrective oversight that will include how McSherr staff will be monitored to prevent recurrence · IDT will review observation logs monthly to assure unscheduled night visits are completed · All staff are required to complete hourly checks for assigned consumers on every night shift · Staff will document on tracking sheet that hourly check has been completed · House Manager will review daily or within 72 hours on the weekend, to ensure staff completed hourly checks · McSherr is contacting Accel (provider of electronic record keeping) to see if hourly checks can be date and timestamped for each staff assuring they are awake and caring for consumers · Failure to report allegations of suspected neglect in a timely manner will result in staff discipline per McSherr policy, state and federal regulations and the law. · Social Services Coordinator will contact each consumer at South B Street in person and each South B Street employee through Accel every 30 days to ask if any staff have been 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2014	
NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST				STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>that she had worked with [staff #10] one night and she (staff #10) had went (sic) to sleep roughly around 10:30 pm and slept for a few hours. Staff 1 stated 'yes, they are sitting at the table talking with each other and not doing any work on Sat. (Saturday) and Sun. (Sunday) mornings when 3rd shift leave.'</p> <p>__ Staff 2: Stated 'Yes, I do, [staff #10]' to question 1. She (Staff 2) went on to state that when working a 12 hour shift on a Saturday with [staff #10], that [staff #10] had slept and she (Staff 2) had to wake her up and that she (staff #10) did not even do her books.' To question 2, Staff 2 stated 'Not anyone I work with.'</p> <p>__ Staff 3: Stated she (Staff 3) only works the 12 hour shift every Sat. For question 1 Staff 3 stated she worked with [staff #10] her 1st Sat. that she (Staff 3) worked. According to Staff 3 [staff #10] slept in a chair in the 2nd living room. Staff 3 stated that she (Staff 3) and her other co-workers tried to wake [staff #10] up several times. [Staff #10] had stated her back hurt and her mother came by and dropped off some muscle relaxants. According to Staff 3 after taking the medication, [staff #10] slept off and one (sic) all day while working. She (staff #10) only did her showers. To question 2 Staff 3 stated 'No, everybody I usually work with pull their weight.'</p> <p>__ Staff 4: stated 'Yes' to question 1. She</p>		<p>observed or if he/she has been told any staff have been sleeping while at work This will continue for 6 months then will be done on a quarterly basis after 6 months</p> <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. ·Allinvestigations of neglect, including allegations of sleeping while onduty, will include a specific plan ofcorrective oversight that will include how McSherr staff will be monitored toprevent recurrence ·IDTwill review observation logs monthly to assure unscheduled night visits arecompleted ·ResidentialAdministrator will sign off on observation logs each month when visits arecompleted ·All staff are required to completehourly checks for assigned consumers on every night shift ·Staff will document on tracking sheetthat hourly check has been completed ·House Manager will review daily orwithin 72 hours on the weekend, to ensure staff completed hourly checks ·McSherr is contacting Accel (providerof electronic record keeping) to see if hourly checks can be date and timestamped for each staff assuring they are 				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2014
NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST			STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>(Staff 4) stated that she worked with [staff #10] on a Saturday and [staff #10] 'slept pretty much all day.' Staff 4 stated she and the other staff tried to get her (staff #10) up several times. To question 2 staff 4 stated 'yes and no.' She stated when smokers go out and smoked every hour this could be neglectful to the residents.</p> <p>__Staff 5: stated 'On 2/11/14 I was working with [staff #10] and she only mopped the hallway and at 1:10 am she (staff #10) laid down on the loveseat with the lights out and stated she had her alarm set for every 20 minutes.'</p> <p>According to Staff 5, [staff #10] did not get up until 5:45 am. Later she (staff #10) had stated to staff 5 'You almost got me caught' due to the HM (House Manager) coming into the group home right after she had gotten up.</p> <p>__Staff 6: stated to question 1 that [staff #10] had slept for about 4 hours on a Sunday 3rd shift with her. [Staff #10] woke up herself before the residents got up for the day. To question 2, staff 6 stated she has concerns with some of her co-workers not assisting in morning activities with staff.... The investigation results showed that the allegation was substantiated due to all 6 staff that was interviewed stating [staff #10] had slept during her work hours whether it was a 3rd shift or a weekend 12 hour shift.</p>		<p>awake and caring for consumers</p> <ul style="list-style-type: none"> ·Social Services Coordinator will contact each consumer at South B Street in person and each South B Street employee through Accel every 30 days to ask if any staff have been observed or if he/she has been told any staff have been sleeping while at work This will continue for 6 months then will be done on a quarterly basis after 6 months What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?) ·Social Services Coordinator will interview consumers and staff quarterly (ie. March, June, September, and December) and ask if there are any concerns with co-workers, peers, etc to be proactive. Results obtained will be discussed at the next scheduled IDT. ·House Managers will complete one unscheduled night visit each month ·Residential Administrator will sign off on observation logs each month after night visits are completed ·All staff are required to complete hourly checks for assigned consumers on every night shift ·Staff will document on tracking sheet that hourly check has been completed ·House Manager will review daily or within 72 hours on the 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2014	
NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST				STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>[Staff #10] was terminated on 2/14/14."</p> <p>The 2/14/14 BDDS report indicated on 2/8/14 "McSherr's SW was made aware of an allegation of neglect on 2/13/14, which stated that [staff #11] was sleeping during her 3rd shifts, at the [address of the facility] group home. McSherr's SW was made aware of this while conducting another investigation. [Staff #11] was suspended on 2/13/14 while the SW conducted an investigation into this allegation. The investigation was completed on 2/14/14. The results of the investigation indicated that the allegation was unsubstantiated. The investigation consisted of interviewing the 2 staff members that work with [staff #11] and 4 McSherr Residents.... Staff 2 stated that [staff #11] may doze 10 minutes during her shift, but does not sleep hours. The results of the investigation showed that the allegation was not substantiated due to not enough facts/evidence to prove [staff #11] is sleeping for 8 to 10 hours during her shift. [Staff #11] was taken off of suspension on 2/14/14. She (staff #11) will be re-trained on what Neglect is and McSherr's policy concerning sleeping on the job. This training is scheduled for 2/18/14."</p> <p>The 3/5/14 follow up BDDS report indicated "The results of the investigation</p>		<p>weekend, to ensure staff completed hourly checks</p> <ul style="list-style-type: none"> ·McSherr is contacting Accel (providerof electronic record keeping) to see if hourly checks can be date and timestamped for each staff assuring they are awake and caring for consumers ·Social Services Coordinator will contact each consumer at South B Street in person and each South B Street employee through Accel every 30 days to ask if any staff have been observed or if he/she has been told any staff have been sleeping while at work This will continue for 6 months then will be done on a quarterly basis after 6 months <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"> ·ResidentialAdministrator will monitor through review of observation logs ·SocialServices Coordinator will monitor through quarterly interview of consumers andstaff to determine if there are any deficiencies in services, including neglect ·ResidentialAdministrator will review all investigations to ensure that corrective actionsare included. ·House Manager will review night timechecks daily or within 72 hours on the weekend, to ensure staff completedhourly 				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2014	
NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST				STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>into [staff #11] sleeping during her 3rd shift indicated that the allegation of her sleeping 8 to 10 hours was unsubstantiated. When the staff member that originally reported this allegation was asked on 2/13/14 'Did you ever feel like co-workers sleeping were neglecting the residents' she stated 'No never felt like co-workers sleeping was neglecting residents because I take care of all 8 (clients).' The morning of 2/14/14, this staff member (staff 1) called and stated that she was going to 'take back what she said.' When the SSD asked her what she meant staff 1 stated 'it's a lie.' When staff 1 was asked if she was stating that her original report was a lie, she stated, 'Well McSherr always takes what the residents say over the staff.' The SSD explained to Staff 1 that during an investigation everything is looked at. At the end of the conversation, the SSD asked staff 1 if she still wanted to take back what she had originally reported, and staff 1 said 'No, I can't do it because it wouldn't be right.' The investigation did not turn up enough evidence to prove the original allegation. Staff 1 changed her report twice, staff 2 indicated she may doze, the 4 residents stated they had never seen a staff member sleep, and [staff #11] denied sleeping. McSherr did a training on 2/20/14 with every staff who works at the [address of facility] group home, including [staff</p>		<p>checks ·McSherr is contacting Accel (providerof electronic record keeping) to see if hourly checks can be date and timestamped for each staff assuring they are awake and caring for consumers ·Social Services Coordinator will contact each consumer at South B Street in person and each South B Street employee through Accel every 30 days to ask if any staff have been observed or if he/she has been told any staff have been sleeping while at work This will continue for 6 months then will be done on a quarterly basis after 6 months What is the date by which the systemic changes will be completed? 10/27/2014 RespectfullySubmitted, RosemaryTaylor, Residential Administrator</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2014
NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST			STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>#11], on McSherr's policy of sleeping on the job. The staff was trained at this time that any form of sleeping on the job will not be tolerated and will be considered neglect. It was also stated at the training that any staff working with another staff that is sleeping will be just as guilty if they do not try to wake up their co-worker or do not report it to their manager."</p> <p>Review of the monthly observation checklists for the clients living in the group home (clients #1, #2, #3, #4, #5, #6, #7 and #8) from February 2014 to August 2014 on 9/23/14 at 2 PM indicated no unscheduled visits by administrative staff to the group home for the night shift were made in May and/or July 2014.</p> <p>The facility records indicated no specific plan of corrective oversight and/or how the facility staff would be monitored to prevent the neglect in regard to staff sleeping from reoccurrence. The facility records indicated no documentation of administrative and/or supervisory staff observations and/or monitoring.</p> <p>During interview with the SSD on 9/23/14 at 3 PM the SSD was asked did the investigative summary include how the facility would monitor the staff to</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/29/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST	STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000225	<p>ensure clients were not being neglected due to staff sleeping. The SSD stated, "We retrained the staff on neglect and I think [name of home manager] does monthly drop in visits." The SSD indicated the drop in visits were not something new and to her knowledge the home managers had always done unscheduled drop in visits once a month just to see how things were going in the group home. The SSD indicated the investigative summary did not include a plan of corrective oversight of how the facility would monitor the staff to ensure clients were not being neglected due to staff sleeping while on duty.</p> <p>9-3-2(a)</p> <p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include, as applicable, vocational skills. Based on observation, record review and interview for 1 of 4 sample clients (#3), the facility failed to assess the client's work interests and/or the client's present and future employment options.</p> <p>Findings include:</p> <p>Observations were conducted at the</p>	W000225	<p>Name and Address of Provider: McSherr, Inc., 4412 So. B. Street, Richmond, IN</p> <p>Date Survey Completed: 9/29/2014</p> <p>Provider Identification Number: 15G457</p> <p>Survey Event ID: ZXU211</p> <p>Finding: W225- The facility failed to assess the client's work interests and/or the client's</p>	10/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2014	
NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST				STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>group home on 9/22/14 between 4 PM and 6:30 PM, on 9/23/14 between 6 AM and 8 AM and at the DP (Day Program) on 9/22/14 from 11 AM to 12:10 PM. Client #3 was a pleasant and verbal individual. Client #3 wore a gait belt and ambulated with an unsteady gait while using a cane. While ambulating the staff provided client #3 with stand by and hands on/contact guard assistance. Client #3 had no movement of his right arm/hand and used his left hand to move his right arm.</p> <p>Client #3's record was reviewed on 9/23/14 at 1 PM.</p> <p>__ Client #3's Professional Staff Notes from the QIDP (Qualified Intellectual Disabilities Professional) indicated on 6/12/14 the QIDP spoke with client #3 about his placement at the DP and "[Client #3] verbally indicated that he did not like it because all he does is color. QIDP explained that perhaps he could do other activities such as math. QIDP did tell [client #3] that I (the QIDP) would work on his placement in that area."</p> <p>__ Client #3's Day Services/Vocational assessment of 11/6/13 indicated client #3 was capable of working. The assessment did not include client #3's work interests and/or present and future employment options. Client #3's record indicated no further vocational assessments for</p>		<p>present and future employment options.</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"> ·McSherr vocational component of FARS assessment will be revised to include consumer work interest, desired community work areas, feel work area is appropriate for him/her ·McSherr QIDP will review McSherr vocational component and AWS workshop assessment annually with the IDT ·Client #3 was interviewed on October 8, 2014 regarding his vocational and community employment interests ·McSherr and client #3 agreed that he will participate in the workshop two days per week from 12-2. This will be done for a 90-day probationary period to see how he does. ·Client #3, Social Services Coordinator, and QIDP are meeting on October 23rd to implement the planned return to workshop ·Group Home staff member will be with client #3 at the workshop for two weeks to monitor for safety <p>How will you identify other residents having the potential</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2014
NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST			STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>review.</p> <p>During interview with client #3 on 9/22/14 at 11:15 AM, client #3 indicated he did not like being at the DP and wanted to go back to the workshop to make money. Client #3 stated he was doing paid work at the facility workshop in 2013 but was told he had to stop going to the workshop and would have to go to the facility DP because "I was falling and somebody had to be with me." When asked what he did while at the day program, client #3 stated, "Math problems and color." Client #3 indicated the DP was not paid work. Client #3 indicated he was able to use his right hand to work and he would like the opportunity to work and to make money. Client #3 stated, "I want to go back downstairs. I make big bucks down there." Client #3 indicated he did not know what alternative vocational opportunities were available for him.</p> <p>Interview with the PD (Program Director) of the workshop on 9/22/14 at 11:30 AM indicated client #3 had a history of falls and injuries from falls. The PD indicated when client #3's falls increased, the facility provided client #3 with a staff to supervise and assist client #3 while at the workshop to prevent falls. The PD stated client #3's falls decreased, "But we don't</p>		<p>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. ·McSherr vocational component of FARS assessment will be revised to include consumer work interest, desired community work areas, feel work area is appropriate for him/her ·McSherr QIDP will review McSherr vocational component and AWS workshop assessment annually with the IDT <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"> ·Social Services Coordinator will interview consumers and staff quarterly (ie. March, June, September, and December) and ask if there are any concerns with co-workers, peers, work, home etc to be proactive in dealing with issues. Results obtained will be discussed at the next scheduled IDT. ·QIDP monitors workshop activity quarterly ·Health Services Coordinator will assess any reported ambulation issues ·McSherr vocational component of FARS assessment will be revised to include consumer work interest, desired community work areas, feel work area is 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2014	
NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST				STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>have the staff to be able to provide him 1:1 (one staff to one client) supervision." The PD indicated client #3 was capable of working as long as he had a staff with him to prevent him from falls while getting up and down on the workshop floor and traversing the steep ramp back and forth to the break room.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 9/23/14 at 12:30 PM indicated the IDT (Interdisciplinary Team) had decided to move client #3 to the DP to be able to provide client #3 a safer environment during the day due to falls. The QIDP indicated the DP was not a paid work program and the clients at the DP were provided supervised activities, watched television and worked on crafts. When asked how the facility was addressing client #3's request to work and to be able to make money, the QIDP indicated the IDT had not looked at other vocational opportunities and/or options for client #3 to be able to do paid work. The QIDP indicated client #3's vocational assessment did not include an assessment of client #3's work interests and/or present and future employment options.</p> <p>9-3-4(a)</p>		<p>appropriate for him/her</p> <ul style="list-style-type: none"> ·McSherr QIDP will review McSherrvocational component and AWS workshop assessment annually with the IDT <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"> ·SocialServices Coordinator will monitor through quarterly interview of consumers andstaff to determine if there are any deficiencies in services, including neglect ·QIDPmonitors workshop activity quarterly ·HealthServices Coordinator will assess any reported ambulation issues ·McSherr vocational component of FARSassessment will be revised to include consumer work interest, desired communitywork areas, feel work area is appropriate for him/her ·McSherr QIDP will review McSherrvocational component and AWS workshop assessment annually with the IDT <p>Whatis the date by which the systemic changes will be completed? 10/20/2014</p> <p>RespectfullySubmitted, RosemaryTaylor, Residential</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/29/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST	STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W000227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, interview and record review for 1 additional client (#5), the client's Individual Support Plan (ISP) failed to address the client's identified behavior of SIB (Self Injurious Behavior) of picking at her skin.</p> <p>Findings include:</p> <p>Observations were conducted at the DP (Day Program) on 9/22/14 from 10 AM to 11 AM. Client #5 was observed to have three circular wounds of .5 to 1.5 cm (centimeters) in diameter on her right forearm and two on her left forearm that were scabbed over. At 10:15 AM client #5 was interviewed. While talking to client #5 she picked at the scabs on her arms. A small amount of dried blood was smeared from one of the scabs on her left arm. When asked what had happened to her arms, client #5 stated, "Oh, I was just picking. It's nothing. I always do that."</p> <p>Client #5's record was reviewed on 9/23/14 at 3 PM. Client #5's 1/29/14 ISP (Individual Support Plan) indicated no</p>	W000227	<p>Administrator</p> <p>Name and Address of Provider: McSherr, Inc., 4412 So. B. Street, Richmond, IN</p> <p>Date Survey Completed: 9/29/2014</p> <p>Provider Identification Number: 15G457</p> <p>Survey Event ID: ZXU211</p> <p>Finding: W227– the client's Individual Support Plan (ISP) failed to address the client's identified behavior of SIB (Self Injurious Behavior) of picking at her skin.</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 #5 does not have a documented history of engaging in SIB ·QIDP will write behavioral guidelines for skin picking for Client #5 ·Health Services Coordinator will develop a High Risk Plan for skin integrity for Client #5 ·Client #5 is on a daily body 	10/20/2014
---------	--	---------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2014
NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST			STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>plan of care to address client #5's identified SIB of picking at her skin.</p> <p>Interview with staff #2 on 9/22/14 at 5:10 PM indicated client #5 would sometimes pick at her skin on her arms and stated, "But I've never noticed it to be a problem." Staff #2 indicated client #5 was capable of telling the staff when she was injured and/or what happened to her.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 9/23/14 at 3:15 PM indicated client #5's ISP did not address skin picking and client #5 did not have a BSP (Behavior Support Plan) and/or any targeted behaviors. The QIDP indicated she was not aware client #5 had issues with skin picking.</p> <p>9-3-4(a)</p>		<p>check asof October 1, 2014</p> <ul style="list-style-type: none"> ·IDT will monitor the above monthly <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. ·HealthServices Coordinator does a body check quarterly and checks for skin integrity <p>lfskin issues are noted:</p> <ul style="list-style-type: none"> ·QIDP will write behavioral guidelinesfor skin picking ·Health Services Coordinator willdevelop a High Risk Plan for skin integrity ·Daily body checks will be implemented ·IDT will monitor the above monthly <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"> ·SocialServices Coordinator will interview consumers and staff quarterly (ie. March,June, September, and December) and ask if there are any concerns with co-workers,peers, work, home etc to be proactive in dealing with 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2014
NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST			STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
			<p>issues. Results obtained will be discussed at the next scheduled IDT.</p> <ul style="list-style-type: none"> · Health Services Coordinator does a body check quarterly and checks for skin integrity If skin issues are noted: <ul style="list-style-type: none"> · QIDP will write behavioral guidelines for skin picking · Health Services Coordinator will develop a High Risk Plan for skin integrity · Daily body checks will be implemented · IDT will monitor the above monthly <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"> · Social Services Coordinator will monitor through quarterly interview of consumers and staff to determine if there are any deficiencies in services, including neglect · Health Services Coordinator and QIDP will report at monthly IDT if any trends are noted from body checks or review of daily notes <p>What is the date by which the systemic changes will be completed? 10/20/2014</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2014	
NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST				STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on record review and interview for 2 of 4 sampled clients (#2 and #4), the clients' ISPs (Individualized Support Plans) failed to address how the staff were to monitor client #2 while near hot items, the stove and/or oven and how the staff were to monitor client #4 while in his bedroom.</p> <p>Findings include:</p> <p>1. Observations were conducted at the group home on 9/22/14 between 4 PM and 6:30 PM. At 4:30 PM the staff began the evening meal preparation. Two pans were placed on the stove, one with water to boil the eggs for a tuna salad and the other to cook broccoli. While the pots were heating up client #2 was in the kitchen near the stove and placed his hands close to the sides of both pots near the bottom of the pots and close to the burners to feel the heat. Staff #2 was in the kitchen with client #2 at the time and verbally prompted client #2 to not put his hands close to the pots on the stove.</p>	W000240	<p>Respectfully Submitted, Rosemary Taylor, Residential Administrator</p> <p>Name and Address of Provider: McSherr, Inc., 4412 So. B. Street, Richmond, IN</p> <p>Date Survey Completed: 9/29/2014 Provider Identification Number: 15G457 Survey Event ID: ZXU211</p> <p>Finding: W240 - the clients' ISPs (Individualized Support Plans) failed to address how the staff were to monitor client #2 while near hot items, the stove and/or oven and how the staff were to monitor client #4 while in his bedroom</p> <p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice? · Behavioral consultant, Glen Plaster, has written behavioral guidelines for potentially dangerous behavior near a source of heat for client #2</p>	10/20/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2014	
NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST				STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Client #2 responded and pulled his hands away and backed away from the stove. Within a few minutes client #2 again returned to the stove and stuck the tip of his finger down into the pot with the broccoli to see if the water was beginning to warm. Staff #2 was in the kitchen at the time but did not observe client #2 put his finger down into the pot on the stove. This surveyor informed staff #2 of what client #2 had just done and staff #2 immediately prompted client #2 to step away from the stove. Staff #2 stated, "Yeah, we have to watch him (client #2) cause he has this thing about putting his hand close to something hot." Staff #2 was asked how are the staff to monitor client #2 while a meal is being prepared. Staff #2 stated, "We just try to watch him. He has a goal for that." During the remainder of the meal preparation client #2 was in and out of the kitchen area and close to the stove and oven. Client #2 did not have direct staff supervision each time he was in the kitchen and near the stove.</p> <p>Client #2's record was reviewed on 9/23/14 at 12 PM. Client #2's 11/14/13 ISP indicated an objective for client #2 not to touch the stove or the oven during dinner meal preparation with verbal cues from the staff. The ISP indicated "If staff observe that he appears to be going to</p>		<ul style="list-style-type: none"> ·QIDP will include auditory monitor inclient #4's ISP ·Social Services Coordinator will getHuman Rights Approval ·QIDP and Social Services Coordinatorwill inservice staff on the behavioral guidelines and use of the auditorymonitor ·IDT will monitor the above monthly <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. ·House management team will monitorduring meal preparations ·House management team will beinserviced at quarterly house meeting on auditory monitor usage ·Laminated auditory monitorinstructions will be posted in the home ·Any concerns with the above will bediscussed with IDT monthly <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"> ·Administrative/Professional staff willmonitor through observation 				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/29/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST	STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>reach out to touch a burner or inner oven - staff are to immediately provide verbal and/or physical redirection." Client #2's ISP did not include how the staff were to supervise and monitor client #2 while in the kitchen and during meal preparation.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 9/23/14 at 2 PM indicated client #2's ISP did not include how the staff were to monitor client #2 while in the kitchen and a meal was being prepared.</p> <p>2. Observations were conducted at the group home on 9/22/14 between 4 PM and 6:30 PM and on 9/23/14 between 6 AM and 8 AM. During both observation periods an auditory monitor was observed in the kitchen/dining area of the home. Interview with staff #1 on 9/22/14 at 5 PM indicated the monitor was used to listen for client #4 while in his bedroom so the staff would know when he was getting out of his bed.</p> <p>Client #4's record was reviewed on 9/23/14 at 2 PM. Client #4's 10/1/13 ISP indicated client #4 was blind and required staff assistance while ambulating and for all ADLs (Adult Daily Living Skills). Client #4's ISP did not include the use of an auditory monitor in client #4's bedroom and/or include how the staff</p>		<p>·Any concerns will be discussed with IDT monthly</p> <p>·House Management team will monitor mealtime observations and report to IDT</p> <p>·House Management team will monitor use of auditory monitor and report any concerns to the IDT</p> <p>·QIDP will revise ISP and develop plans as health and safety concerns arise</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> <p>·Monthly and Annual IDT will monitor</p> <p>·Residential Administrator will monitor monthly through IDT reporting process</p> <p>What is the date by which the systemic changes will be completed? 10/20/2014</p> <p>Respectfully Submitted, Rosemary Taylor, Residential Administrator</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/29/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST	STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000263	<p>were to monitor client #4 while in his bedroom to provide for client #4's needs.</p> <p>Interview with the QIDP on 9/23/14 at 2 PM indicated an auditory monitor was utilized in client #4's bedroom for the staff to be able to hear client #4 while he was in his bedroom. The QIDP stated the use of an auditory monitor "should be in [client #4's] ISP."</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on interview and record review for 1 of 3 sampled clients (#4) with restrictive programs, the facility failed to obtain written informed consent from the client's legal representative for the client's restrictive program and/or the use of an auditory monitor in client #4's bedroom.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 9/22/14 between 4 PM and 6:30 PM and on 9/23/14 between 6</p>	W000263	<p>Name and Address of Provider: McSherr, Inc., 4412 So. B. Street, Richmond, IN</p> <p>Date Survey Completed: 9/29/2014</p> <p>Provider Identification Number: 15G457</p> <p>Survey Event ID: ZXU211</p> <p>Finding: W263– the facility failed to obtain written informed consent from the client's legal representative for the client's restrictive program and/or the use of an auditory monitor in client #4's bedroom.</p>	10/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2014
NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST			STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>AM and 8 AM. During both observation periods an auditory monitor was observed in the kitchen/dining area of the home. Interview with staff #1 on 9/22/14 at 5 PM indicated the monitor was used to listen for client #4 while in his bedroom so the staff would know when he was getting out of his bed.</p> <p>Client #4's record was reviewed on 9/23/14 at 2 PM. Client #4's 5/12/2014 BSP (Behavior Support Plan) indicated client #4 received Paxil 20 mg a day for depression. Client #4's record indicated client #4 was represented by a legal guardian. Client #4's record indicated the facility had not obtained written informed consent from client #4's guardian for client #4's restrictive program including the use of Paxil and/or the use of an auditory monitor in client #4's bedroom.</p> <p>Interview with the SSD (Social Service Director) on 9/23/14 at 3 PM, the SSD indicated she had not received written informed consent from client #4's legal representative for client #4's BSP that included the use of Paxil and for the use of an auditory monitor in client #4's bedroom.</p> <p>9-3-4(a)</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 #4's family was notified on September 23rd and returned signed document on September 24th regarding use of paxil and auditory monitor · IDT will monitor the above <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. · Request will be emailed to families/guardians for those that have email capabilities. Other family members/guardians will receive the documents via U.S. mail. · Social Services Coordinator will develop a tracking form as a reminder to get approvals · IDT will monitor the above monthly <p>What measures will be put into place or what systemic changes you will make</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2014
NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST			STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W000312	483.450(e)(2)		<p>toensure that the deficient practice does not recur?)</p> <ul style="list-style-type: none"> ·Requestwill be emailed to families/guardians for those that have emailcapabilities. Other familymembers/guardians will receive the documents via U.S. mail. ·SocialServices Coordinator will develop a tracking form as a reminder to getapprovals ·IDT will monitor the above monthly <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"> ·SocialServices Coordinator will include with monthly IDT report status of requiredguardianship approvals. ·ResidentialAdministrator will monitor ·MonthlyIDT will monitor <p>Whatis the date by which the systemic changes will be completed? 10/20/2014</p> <p>RespectfullySubmitted, RosemaryTaylor, Residential Administrator</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/29/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST	STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>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 1 of 3 sampled clients receiving medications to control behaviors (#2), the facility failed to implement a plan of reduction to reduce and eventually eliminate the behaviors for which each psychoactive medication was to target.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 9/23/14 at 12 PM. Client #2's physician's orders of 9/17/14 indicated client #2 took Olanzapine 5 milligrams a day for behavior modification. Client #2's IBP (Individualized Behavior Plan) dated 5/12/14 indicated client #2 had targeted behaviors of verbal aggression, making negative comments and non cooperation. Client #2's IBP indicated no plan of reduction for the Olanzapine.</p> <p>During interview with the QIDP (Qualified Intellectual Disabilities Professional) on 9/23/14 at 2 PM, the QIDP stated, "No, he (client #2) doesn't have a plan of reduction for his Zyprexa (Olanzapine). I overlooked it."</p>	W000312	<p>Name and Address of Provider: McSherr, Inc., 4412 So. B. Street, Richmond, IN Date Survey Completed: 9/29/2014 Provider Identification Number: 15G457 Survey Event ID: ZXU211 Finding: W312– the facility failed to implement a plan of reduction to reduce and eventually eliminate the behaviors for which each psychoactive medication was to target.</p> <p>What corrective action(s) will be accomplished for these residents found to have been affected by · Client #2 had a reduction of Zyprexa on January 10, 2014. On February 10, 2014 it was increased again due to pacing, agitation, and suggestion of self-harm. · The IBP was revised on September 30, 2014 to address a future attempt at medication reduction. How will you identify other residents having the potential to be affected by the same deficient practice and what</p>	10/20/2014
--	--	---------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2014
NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST			STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	9-3-5(a)		<p>corrective action will be taken?</p> <ul style="list-style-type: none"> ·Allconsumers have the potential to be affected. ·QIDPreports at monthly IDT, ·Mostrecent medication reduction and IBP's are revised as needed to address medreduction plans <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"> ·QIDP sends quarterly review reports ofconsumer progress and IBP status to Residential Administrator for review <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"> ·ResidentialAdministrator will monitor quarterly ·MonthlyIDT will monitor <p>Whatis the date by which the systemic changes will be completed? 10/20/2014</p> <p>RespectfullySubmitted, RosemaryTaylor, Residential Administrator</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2014	
NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST				STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000323	<p>483.460(a)(3)(i) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on record review and interview for 2 of 4 sampled clients (#1 and #4), the facility failed to ensure the clients' hearing was evaluated annually.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 9/23/14 at 11 AM. Client #1's record indicated client #1 was an elderly gentleman that used a cane for ambulation. The record indicated client #1 was admitted to the facility on 6/23/14. Client #1's physical evaluation of 6/24/14 did not indicate a hearing evaluation. Client #1's record indicated no hearing evaluation.</p> <p>Client #4's record was reviewed on 9/23/14 at 2 PM. Client #4's record indicated client #4 was blind. Client #4's hearing evaluation dated 8/22/13 indicated client #4 was to be seen annually for a hearing evaluation.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 9/23/14 at 5 PM indicated client #4's current hearing evaluation was the one of</p>	W000323	<p>Name and Address of Provider: McSherr, Inc., 4412 So. B. Street, Richmond, IN</p> <p>Date Survey Completed: 9/29/2014</p> <p>Provider Identification Number: 15G457</p> <p>Survey Event ID: ZXU211</p> <p>Finding: W323— the facility failed to ensure the clients' hearing was evaluated annually.</p> <p>What corrective action(s) will be accomplished for these residents found to have been affected by</p> <ul style="list-style-type: none"> · Client #1 and Client #2's family physician will be contacted to schedule a hearing evaluation · Recommendations from hearing evaluation will be implemented immediately. <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. · Health Services Coordinator and House Managers will review all consumer records to assure that all consumers have had an 	10/20/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/29/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST	STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	8/22/13. The QIDP indicated client #4 had not had another hearing evaluation since the one of 8/22/13. 9-3-6(a)		<p>initial baseline and annual hearingevaluation</p> <ul style="list-style-type: none"> ·HealthServices Coordinator will enter information re: evaluations into Medical Moduleof Accel by January 1, 2015 to track allevaluations including hearing evaluations ·McSherrpolicy will be updated to reflect that hearing evaluations for consumers aretracked in Accel . ·IDTwill monitor monthly through review of Accel notifications for evaluations due. <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"> ·HealthServices Coordinator and House Managers will review all consumer records toassure that all consumers have had an annual hearing evaluation ·HealthServices Coordinator will enter information re: evaluations into Medical Moduleof Accel by January 1, 2015 to track all evaluations including hearingevaluations ·McSherrpolicy will be updated to reflect that hearing evaluations for consumers aretracked in Accel . ·IDTwill monitor monthly through review of Accel notifications for evaluations due. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2014
NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST			STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W000331	483.460(c) NURSING SERVICES The facility must provide clients with nursing		<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"> · House Manager will monitor through review of consumer records · Health Services Coordinator will monitor through Accel notifications · IDT (Residential Administrator, Health Services Coordinator, Social Services Coordinator, QIDP) will monitor monthly through review of evaluation tracking in Accel. · QIDP, Social Services Coordinator, Health Services Coordinator, House Manager, and Residential Administrator will monitor to determine the need for a more frequent evaluation through observation at the home, day program, and in the community. If problems with hearing are suspected/observed, an evaluation will be scheduled. <p>What is the date by which the systemic changes will be completed? 10/20/2014</p> <p>Respectfully Submitted, Rosemary Taylor, Residential Administrator</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2014	
NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST				STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>services in accordance with their needs.</p> <p>Based on observation, record review and interview for 1 of 4 sampled clients (#1), the facility nursing services failed to develop and implement a specific plan of care in regard to client #1's medical needs.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 9/22/14 between 4 PM and 6:30 PM and on 9/23/14 between 6 AM and 8 AM. Client #1 was a retired elderly gentleman that walked with a slow gait and used a cane to support himself.</p> <p>Client #1's record was reviewed on 9/23/14 at 11 AM. Client #1's record indicated client #1 had diagnoses of, but not limited to, Osteoarthritis (a degenerative joint disease), Constipation, Dysphasia (difficulty swallowing), Chronic Rhinitis (irritation/inflammation of the mucous membranes inside the nose), Hypokalemia (low levels of potassium in the blood that can result in abnormal heart rhythms, fatigue, muscle weakness and paralysis), Anemia (a below normal volume of red cells in the blood), Hypertension (high blood pressure), Ascending Aorta Aneurysm (a bulge in the portion of the aorta closest to</p>	W000331	<p>Name and Address of Provider: McSherr, Inc., 4412 So. B. Street, Richmond, IN</p> <p>Date Survey Completed: 9/29/2014</p> <p>Provider Identification Number: 15G457</p> <p>Survey Event ID: ZXU211</p> <p>Finding: W331– the facility nursing services failed to develop and implement a specific plan of care in regard to client #1's medical needs.</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 will develop and implement High Risk plans for client #1 for all primary medical diagnoses · Health Services Coordinator will develop a Protocol from the High Risk Plans that includes “when to call the Health Services Coordinator.” · Staff will be trained on the High Risk Plans and Protocols · High Risk Plans will be reviewed at the IDT every six months or more frequently as deemed necessary <p>How will you identify other residents having the potential to be affected by the same deficient practice and what</p>	10/20/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2014	
NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST				STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>the heart), Esophageal reflux (a backup of the stomach contents into the esophagus), Lower Back Pain, Edema (swelling) and Malnutrition.</p> <p>Client #1's quarterly physician's orders of 9/18/14 indicated client #1 received the following medications daily: ___ Spironolactone and Furosemide for edema ___ There-M and Ferrous Sulfate for anemia ___ Loratadine for allergies ___ Zantac for Esophageal Reflux ___ Senexon-S for constipation ___ Mag-Oxide and Vitamin D3 for malnutrition and dietary supplements. ___ Metoprolol for hypertension ___ Potassium Chloride for Hypokalemia</p> <p>Client #1's Nutritional Assessment dated 6/23/14 indicated "Consuming Mechanical Soft diet chopped meats at this time. Does appear accepting of this texture.... Review of Dx (diagnoses) and nutritional concerns with GERD (Gastric Esophageal Reflux Disease), anemia, constipation, malnutrition, edema, HTN (hypertension) and Dysphagia. Is on multiple meds to assist and should be monitored closely as Spironolactone SE conflict (sic) with use of KCL and Furosemide.... Discussion with nursing regarding recent reports of vomiting-</p>		<p>correctiveaction will be taken?</p> <ul style="list-style-type: none"> ·Allconsumers have the potential to be affected ·Ameeting will be scheduled within 30 days to determine all consumer's needs forHigh Risk Plans and Protocols ·HealthServices Coordinator will develop and implement High Risk plans for allconsumers as needed ·HealthServices Coordinator will develop a Protocol from the High Risk Plans thatincludes "when to call the Health Services Coordinator." ·Staffwill be trained on the High Risk Plans and Protocols ·HighRisk Plans will be reviewed at the IDT every six months or more frequently asdeemed necessary <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"> ·HealthServices Coordinator will develop and implement High Risk plans for allconsumers as needed ·HealthServices Coordinator will develop a Protocol from the High Risk Plans thatincludes "when to call the Health Services Coordinator." ·Staffwill be trained on the High Risk Plans and Protocols ·HighRisk Plans will be reviewed at the IDT every six months or more frequently asdeemed necessary 				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/29/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST	STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>almost daily. Recently off of GERD med (medication).... Nursing questions possible Hiatal Hernia (a condition where part of the stomach extends through the diaphragm into the chest cavity)? Gallstones (hard, pebble-like deposits that form inside the gallbladder)? This RD (Registered Dietician) agrees that daily emesis is of concern and should be discussed with physician as he may need further testing. Nutritional concern with need for Mech (Mechanically) altered diet and recent c/o (complaints of) emesis daily. RD to cont (continue) to monitor x (times) 3 mos. (months). Recs (Recommendations): 1. Cont current diet at this time. 2. Cont to encourage routine activity for good health habits. 3. Wt (weight) monthly or as ordered. 4. 2014/15 - maintain IBWR (Ideal Body Weight Record) thru 7/15. 5. Avoid natural licorice and salt subs (substitutes) d/t (due to) med SE (Spironolactone). 6. Physician to consider NAS (No Added Salt) addition to diet order d/t (due to) HTN Dx. If new admission labs WNL (Within Normal Limits). 7. See physician regarding daily emesis if not resolved-may need further testing to r/o (rule out) concerns with swallowing or constipation."</p> <p>Client #1's record indicated a High Risk Plan for choking due to Dysphagia.</p>		<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"> ·Itwill be monitored by the IDT on a monthly basis ·HealthServices Coordinator will complete periodic reviews of the High Risk Plans withstaff ·HouseManager will review with staff as deemed necessary <p>Whatis the date by which the systemic changes will be completed? 10/20/2014 (All high risk plans will not be completed by10/20/2014. They will be completed nolater than January 1, 2014.</p> <p>RespectfullySubmitted, RosemaryTaylor, Residential Administrator</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/29/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST	STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W009999	<p>Client #1's record indicated no nursing plan of care and/or risk plan in regard to client #1's Osteoarthritis, Constipation, Chronic Rhinitis, Hypokalemia, Anemia, Hypertension, Ascending Aorta Aneurysm, Esophageal reflux, Lower Back Pain, Edema and Malnutrition. Client #1's record failed to indicate what the staff were to monitor and document and when the staff were to call the nurse in regard to client #1's medical needs.</p> <p>Interview with the facility's RN on 9/23/14 at 1 PM indicated he was new to the facility and would need to review and revise client #1's health needs and plans. The RN indicated client #1's only risk plan/health care plan was for choking due to dysphagia.</p> <p>9-3-6(a)</p> <p>State Findings:</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met.</p> <p>460 IAC 9-3-2 Resident protections (c) The residential provider shall</p>	W009999	<p>Name and Address of Provider: McSherr, Inc., 4412 So. B. Street, Richmond, IN</p> <p>Date Survey Completed: 9/29/2014</p> <p>Provider Identification Number: 15G457</p> <p>Survey Event ID: ZXU211</p> <p>Finding: W9999– the facility failed to ensure the references provided for staff #3 included more than verification of</p>	10/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2014	
NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST				STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>demonstrate that its employment practices assure that no staff person would be employed where there is: (3) conviction of a crime substantially related to a dependent population or any violent crime. The provider shall obtain, as a minimum,... three (3) references. Mere verification of employment dates by previous employers shall not constitute a reference in compliance with this section.</p> <p>Based on record review and interview, for 1 of 5 staff persons reviewed (staff #3), the facility failed to ensure the references provided for staff #3 included more than verification of employment dates by the employee's previous employer.</p> <p>Findings include:</p> <p>Review of the personnel records on 9/17/14 at 2:30 PM indicated staff #3 was hired 9/8/14. Staff #3's file indicated 3 references. One of the references indicated verification of dates of employment only.</p> <p>Interview with the Administrative Assistant on 9/17/14 at 3 PM indicated three references for staff #3 and one of the three references for staff #3 indicated dates of former employment only.</p>		<p>employment dates bythe employee's previous employer.</p> <p>Whatcorrective action(s) will be accomplished for these residents found to havebeen affected by this finding?</p> <ul style="list-style-type: none"> ·McSherrwill continue to monitor employee #3 that has only dates of employment as a work reference ·McSherrwill continue to complete annual criminal background checks to assure safety ofconsumers at employee #3's worksite ·McSherrwill continue to research the issue to find solutions that other providers maybe using <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 ·Mcsherrwill update the application for employment to include the addition of co-workercontact information ·Inthe event the previous employer will not give a reference other than dates ofemployment and/or job title, Mcsherr Human Resource Department will contactco-workers listed and attempt to obtain a work reference from him/her. ·McSherrwill continue to 				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2014
NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST			STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	9-3-2(c)(3)		<p>complete a criminal background check on all applicants being considered for employment to ensure he/she has not been convicted of a crime.</p> <ul style="list-style-type: none"> ·McSherrwill complete a criminal background check on all employees annually to ensure criminal convictions have not occurred during the course of employment ·Human Resource Department will set employment references up (employer and co-workers if necessary) in Accel as a compliance item to enable electronic tracking no later than January 1, 2015 ·McSherrwill continue to research the issue to find solutions that other providers maybe using <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"> ·Mcsherrwill update the application for employment to include the addition of co-worker contact information ·In the event the previous employer will not give a reference other than dates of employment and/or job title, Mcsherr Human Resource Department will contact co-workers listed and attempt to obtain a work reference from him/her. ·McSherrwill continue to complete a criminal background check on all applicants 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2014
NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST			STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
			<p>beingconsidered for employment to ensure he/she has not been convicted of a crime.</p> <ul style="list-style-type: none"> ·McSherrwill complete a criminal background check on all employees annually to ensurecriminal convictions have not occurred during the course of employment ·HumanResource Department will set employment references up (employer and co-workersif necessary) in Accel as a compliance item to enable electronic tracking nolater than January 1, 2015 ·McSherrwill continue to research the issue to find solutions that other providers maybe using <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 into place?</p> <ul style="list-style-type: none"> ·HumanResource Department will monitor through completion of new hire checklist ·HumanResource Department will monitor through Accel compliance module no later thanJanuary 1, 2015 <p>What is the date by which the systemic changes will be completed? 10/20/2014</p> <p>RespectfullySubmitted, RosemaryTaylor, Residential</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/31/2014

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G457	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2014
NAME OF PROVIDER OR SUPPLIER MCSHERR INC - B ST			STREET ADDRESS, CITY, STATE, ZIP CODE 4412 S B ST RICHMOND, IN 47374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
			Administrator		