STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G579	B. WING		08/22/2016
			-		
NAME OF PRO	OVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
				NNY DR	
MCSHERR	RINC - NEW CAST	TLE	NEW C	CASTLE, IN 47362	
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDENCE NAME OF CORPORATION	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
W 0000		,			
Bldg. 00					
	This visit was for	r a fundamental	W 0000		
1			W 0000		
1	recertification an	d state licensure survey.			
1	Dates of Survey	: 8/16, 8/17, 8/18, and			
	8/22/16.				
,	Easilite, al	001002			
	Facility number:				
1	Provider number				
	AIM number: 10	00239970			
-	These deficiencie	es also reflect state			
'	imanigs in accor	dance with 460 IAC 9.			
(Quality review o	f this report completed			
(on 8/30/2016 by	#09182.			
	,				
	400 400/.!\/0\				
	483.420(d)(3)	NIT OF CLIENTS			
l _	STAFF TREATME				
		ave evidence that all			
	alleged violations	are thoroughly			
	nvestigated.	maniana and interests. Com	W 0154	Nameand Address of Provide	or: 00/21/2016
		review and interview for	W 0154	McSherr, Inc., 496Denny Drive	07/21/2010
		s of abuse, neglect, or		New Castle, IN	<u>,</u>
i	injuries of unkno	own source, the facility		DateSurvey Completed:	
1	failed to thorough	hly investigate injuries		8/22/2016	
	_	ce for clients #2 and #6.		Provider Identification	
'	or anknown soul	co for elicitis #2 and #0.		Number:	
	n: 1: · · · · ·			15G579	
1	Findings include	•		SurveyEvent ID: IZSH11	
				Finding: W154– The facility to	,

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

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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 X3) DATE SURVEY X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 00 COMPLETED 15G579 B. WING 08/22/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 496 DENNY DR MCSHERR INC - NEW CASTLE NEW CASTLE. IN 47362 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG thoroughly investigate injuries of The facility's reportable incident reports, unknown source forclients #2 and internal accident/injury reports, and investigations were reviewed on 8/16/16 Whatcorrective action(s) will be at 12:44pm. accomplished for these residents found to havebeen affected by the deficient 1. Client #2's 6/16/16 accident/injury practice? report indicated "Chip on right tooth ·All future injuries of unknown unknown when found." sourcewill be thoroughly investigated The 7/12/16 completed investigation ·TheAccident & Injury report will be updated to record more indicated client #2 chipped his tooth on specific anddetailed information 6/7/16 and staff were unaware of how he for each unknown injury could have chipped his tooth. The (measurement, location of injuryon body, etc.). investigation did not indicate which tooth Investigationforms for client #2 chipped or how big the chip in Unknown Injuries will be updated client #2's tooth was. The investigation to include more specific did not indicate how the chipped tooth questionsincluding questions help determine if a client is giving was discovered. The investigation did statements that arenot truthful. not indicate why the chipped tooth was ·Staffand clients will be discovered on 6/7/16 and not reported re-interviewed whenever there is until 6/16/16. conflicting and/or unclearstatements given regarding an unknown injury An interview with the RA (Residential ·Ifa staff or client indicates an Administrator), the Social Service injury could have occurred at Coordinator, the QIDP (Qualified workshop, workshopstaff will be Intellectual Disabilities Professional) and interviewed ·Uponcompletion, all unknown the CEO (Chief Executive Officer) was injury investigation documentation conducted on 8/18/16 at 2:30pm. When will be reviewed and signed by a asked how the chipped tooth was party not involved in the discovered, the Social Service investigation ·Allquestions resulting from the Coordinator stated "We aren't really sure, review will be addressed and, if it was just reported discovered by staff." warranted, additional investigation When asked what tooth was chipped and will be conducted how big the chip was, the Social Service ·Allstaff involved in conducting

CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-0391	
	NT OF DEFICIENCIES NOF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G579	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 08/22/2016
	PROVIDER OR SUPPLIEF		496 DE	ADDRESS, CITY, STATE, ZIP CODE ENNY DR CASTLE, IN 47362	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	tooth and just a sinformation is not investigation." 2. Client #6's 6/report indicated on his back. The 7/12/16 combindicated staff we client #6 got the The investigation interviewed. Client indicated "Yes I workshop he was investigation did questioned in rephe bit client #6 a investigation did was re-interviewed stating he bit him not indicate wor interviewed in rephe bit client #6 a An interview with Administrator), Coordinator, the Intellectual Disa the CEO (Chief	s bothering me." The I not indicate staff were gards to client #4 stating at workshop. The I not indicate client #6 red in regards to client #4 no. The investigation did kshop staff were egards to client #4 stating at workshop. th the RA (Residential the Social Service QIDP (Qualified bilities Professional) and Executive Officer) was 18/16 at 2:30pm. When		investigations of injuries of unknown origin willbe retraine new procedures/processes Howwill you identify other residents having the potentiat to be affected by thesame deficient practice and what corrective action will be taken? ·Allconsumers with an unknown injury have the potential to be affected. ·All future injuries of unknown sourcewill be thoroughly investigated ·TheAccident & Injury report be updated to record more specific anddetailed information for each unknown injury (measurement, location of injuryon body, etc.). ·Investigationforms for Unknown Injuries will be updated to include more specific questionsincluding questions in determine if a client is giving statements that arenot truthfull. ·Staffand clients will be re-interviewed whenever there conflicting and/or unclearstatements given regarding an unknown injury. ·Ifa staff or client indicates a injury could have occurred at workshop, workshopstaff will be interviewed. ·Uponcompletion, all unknown injury investigation documentation will be reviewed and signed by party not involved in the	al own /n t will on ted help l. e is un oe wn ation

re-interviewed in regards to client #4

investigation

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		15G579	B. WING		08/22/2016	
NAME OF F	PROVIDER OR SUPPLIEF	2		ADDRESS, CITY, STATE, ZIP CODE		
MCSHEF	RR INC - NEW CAS	TLE		ASTLE, IN 47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	ID PROVIDER'S PLAN OF CORRECTION		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	stating he bit cli	ent #6, the Social Service		·Allquestions resulting from		
	Coordinator stat	ed "No." When asked if		review will be addressed and,		
	any day services	s staff were interviewed		warranted,additional investiga	tion	
	1 , ,	tigation, the Social		will be conducted ·Allstaff involved in conducti	na	
	_	ator stated "No."		investigations of injuries of	119	
	Service Coordin	ator stated No.		unknown origin willbe retraine	d on	
				new procedures/processes		
	3. Client #2's 5/	6/16 accident/injury		Whatmeasures will be put in	to	
	report indicated	"workshop notified staff		place or what systemic		
	of the bruise on	[client #2's] eye and		changes you will make		
	cheek. The brui	se by the eye measures 2		toensure that the deficient		
		s) in diameter and the		practice does not recur?)		
	cheek 3" (Inch)			·All future injuries of unknow	/n	
	CHECK 5 (HICH)	X 1 1/2.		sourcewill be thoroughly		
				investigated		
		npleted investigation		·TheAccident & Injury report	Will	
	indicated "Staff	statements do not		be updated to record more	n l	
	indicate any pos	sible cause of bruising.		specific anddetailed information for each unknown injury	וויי	
		do not indicate that staff		(measurement, location of		
		ercations between client		injuryon body, etc.).		
	and peers as ind			·Investigationforms for		
	•			Unknown Injuries will be upda	ted	
		e investigation did not		to include more specific		
	indicate what qu	lestions staff were asked		questionsincluding questions	help	
	during the inves	tigation.		determine if a client is giving		
				statements that arenot truthful		
	The investigatio	n indicated client #3 was		·Staffand clients will be	. i.	
	_	5/11/16. Client #3's		re-interviewed whenever there	e is	
		ted "[Client #3] stated		conflicting and/or unclearstatements given		
				regarding an unknown injury		
		it client #2 in the eye on		·Ifa staff or client indicates a	ın İ	
	Tuesday."			injury could have occurred at		
				workshop, workshopstaff will b	oe	
	The investigatio	n indicated client #4 was		interviewed		
	interviewed on 5	5/11/16. Client #4's		·Uponcompletion, all unknow	• • • • • • • • • • • • • • • • • • •	
		ted "[Client #4] stated		injury investigation documenta	• • • • • • • • • • • • • • • • • • •	
		up so he hit him and		will be reviewed andsigned by	'a	
	-	-		party not involved in the		
	then [client #2]	hit him. He also stated		investigation		

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15G579	B. W	ING		08/22/	2016
				CTD FET A	ADDRESS CITY STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIEF	t			ADDRESS, CITY, STATE, ZIP CODE		
					NNY DR		
MCSHE	RR INC - NEW CAS	ILE		NEW C	ASTLE, IN 47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	,,_	DATE
	every boy here h	nas hit [client #4] in the			·Allquestions resulting from t	the	
	eye."				review will be addressed and,	if	
					warranted,additional investigat	tion	
					will be conducted		
		n indicated client #2 was			·Allstaff involved in conducti	ng	
	interviewed on 5	5/11/16. Client #2's			investigations of injuries of		
	interview indica	ted "He stated [client #4]			unknown origin willbe retrained	d on	
	hit him in the ev	e a long time ago."			new procedures/processes		
		- ug ugu				.(-)	
	The investigation	n did not indicate staff on			Howwill the corrective action	(S)	
	The investigation did not indicate staff or				be monitored to ensure the		
	clients were re-interviewed in regards to				deficient practicewill not reci	ar	
	clients #2, #3, and #4 reporting client #4				(quality assurance program, etc.) and how will it be put		
	hit client #2 in tl	ne eye. The investigation			intoplace?		
	did not indicate	the workshop staff were			·Administratorwill monitor		
		ng the investigation.			through quarterly review of		
	litter vie vveu duit	ing the my opensument			investigations with Health		
	.	41 41 DA (D. 11 11 1			ServicesCoordinator, Social		
		th the RA (Residential			Services Coordinator, and QID)P	
	· · · · · · · · · · · · · · · · · · ·	the Social Service			·IDTwill monitor through		
	Coordinator, the	QIDP (Qualified			monthly review of Accident &		
	Intellectual Disa	bilities Professional) and			Injury reports		
	the CEO (Chief	Executive Officer) was			·Monitoringwill occur through		
	,	18/16 at 2:30pm. When			review of investigation by outs	ıae	
		•			party ·Staffthat have been retraine	\d	
	I -	kshop staff were			on more thorough investigation		
		ng the investigation, the			of unknown origin willmonitor t		
	Social Service C	Coordinator stated "No."			help prevent recurrence		
	When asked if st	taff and/or clients were			morp provent recurrence		
	re-interviewed in	n regards to clients #2,					
		ting client #4 hit client			Whatis the date by which the	,	
	#2 in the eye, the				systemic changes will be		
					completed? 9/21/2016		
	Coordinator stat	EU INO.					
					RespectfullySubmitted,		
	9-3-2(a)				RosemaryTaylor, Residential		
					Administrator		

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Event ID: IZSH11 Facility ID: 001093

If continuation sheet Page 5 of 14

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G579		î ´	JILDING	ONSTRUCTION OO	(X3) DATE COMPL 08/22/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 496 DENNY DR NEW CASTLE, IN 47362				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
W 0156	483.420(d)(4) STAFF TREATME	ENT OF CLIENTS					
Bldg. 00	reported to the ad representative or to accordance with S working days of the Based on record 3 of 5 allegations injuries of unknown failed to complete clients #2 and #6	state law within five e incident. review and interview for s of abuse, neglect, or own source, the facility te the investigation for b's injuries of unknown	W	0156	Nameand Address of Provide McSherr, Inc., 496Denny Drive New Castle, IN DateSurvey Completed: 8/22/2016 Provider Identification		09/21/2016
	internal accident				Number: 15G579 SurveyEvent ID: IZSH11 Finding: W156—The facility failed to complete the investigation for clients #2 and#6's injuries of unknown source within 5 working days. Whatcorrective action(s) wil accomplished for these residents found to havebeel	l be	
	report indicated unknown when for the investigation	n's conclusion indicated			affected by the deficient practice? ·All future investigations of injuriesof unknown source will completed within 5 working definitions.	l be	
	7/12/16. 2. Client #6's 6/2 report indicated on his back. The investigation	was finalized on 30/16 accident/injury client #6 had red marks a's conclusion indicated was finalized on			TheAccident & Injury report be updated to reflect expecte completiondate for investigation Investigation Investigation Investigation will be update to reflect expected completion datefor investigation Allstaff involved in conduct investigations of injuries of unknown origin willbe retrained ensure compliance with	d on ated า	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

IZSH11

Facility ID: 001093

If continuation sheet

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. Bl	UILDING	00	COMPL	ETED	
		15G579	B. W	ING		08/22/	2016	
				CTDEET	ADDRESS, CITY, STATE, ZIP CODE	<u></u>		
NAME OF I	PROVIDER OR SUPPLIEI	₹		1				
MOCHE		TIE	496 DENNY DR NEW CASTLE, IN 47362					
MCSUEL	RR INC - NEW CAS	oile		NEW C	ASTLE, IN 47302			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	7/12/16.				completion dates			
	3. Client #2's 5/	6/16 accident/injury			Howwill you identify other			
		"workshop notified staff			residents having the potential	al		
	•	•			to be affected by thesame			
		[client #2's] eye and			deficient practice and what corrective action will be			
		se by the eye measures 2			taken?			
	,	s) in diameter and the			·Allconsumers with an unkn	own		
	cheek 3" (Inch)	x 1 1/2".			injury have the potential to be			
					affected.			
	The investigation	n's conclusion indicated			·TheAccident & Injury report	t will		
		was finalized on			be updated to reflect expected			
	7/12/16.	was imanzed on			completiondate for investigation	on		
	//12/10.				·Investigationforms for			
					Unknown Injuries will be upda			
	An interview wi	th the RA (Residential			to reflect expected completion	1		
	Administrator),	the Social Service			datefor investigation			
	Coordinator, the	QIDP (Qualified			·Allstaff involved in conducti	ng		
		bilities Professional) and			investigations of injuries of unknown origin willbe retraine	od to		
		Executive Officer) was			ensure compliance with	u io		
	· ·	· ·			completion dates			
		18/16 at 2:30pm. When						
		the facility had to			Whatmeasures will be put in	to		
	complete investi	gations, the Social			place or what systemic			
	Service Coordin	ator stated "5 working			changes you will make			
	days."				toensure that the deficient			
					practice does not recur?)			
	9-3-2(a)				·Allfuture injuries of unknow	n		
	9-3-2(a)				source will be thoroughly			
					investigated			
					·TheAccident & Injury report			
					be updated to reflect expected			
					completiondate for investigation	וזכ		
					Investigationforms for Unknown Injuries will be upda	nted		
					to reflect expected completion			
					datefor investigation	'		
					·Allstaff involved in conducti	ina		
					investigations of injuries of	.·· <i>ع</i>		
					unknown origin willbe retraine	d to		

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

PRINTED: 10/28/2016 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 15G579	A. BUILDING B. WING	00	COMPLETED 08/22/2016
	PROVIDER OR SUPPLIER RR INC - NEW CASTLE	496 DEN	DDRESS, CITY, STATE, ZIP CODE INY DR ASTLE, IN 47362	
(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 APPROPR DEFICIENCY)	(X5) COMPLETION DATE
			ensure compliance with completion dates ·Reassignmentof staff invo in investigations of Unknown Injuries will allow for moreoversight	· · · · · · · · · · · · · · · · · · ·
			Howwill the corrective actic be monitored to ensure the deficient practicewill not re (quality assurance program etc.) and how will it be put intoplace? Administratoror Designee monitor through quarterly revof investigations with HealthServices Coordinator, Social Services Coordinator, QIDP IDTwill monitor through monthly review of investigation by our party Staffwill be retrained on dof completion for investigation unknown origin Whatis the date by which the systemic changes will be completed? 9/21/2016 RespectfullySubmitted, RosemaryTaylor, Residentia Administrator	cur n, will view and ons gh tside ates ons of
W 0249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has			
ріцу. 00	formulated a client's individual program plan, each client must receive a continuous active			

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Event ID:

IZSH11

Facility ID: 001093

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u> COMPLETED			ETED	
		15G579	B. W	ING		08/22/	08/22/2016	
				CTREET	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER	2						
		T. F			NNY DR			
MCSHER	RR INC - NEW CAS	ILE		NEW C	ASTLE, IN 47362			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI TAG DEFICIENCY)		TF	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)					DATE	
	treatment program	n consisting of needed						
interventions and services in sufficient								
	number and frequ	ency to support the						
		e objectives identified in						
	the individual prog	-						
		ew, and record review	W	249	Nameand Address of Provide		09/21/2016	
	for 1 additional of	client (#4) the facility			McSherr, Inc., 496Denney Drive,			
	failed to address	client #4's identified			New Castle, IN			
	need of physical	aggression toward peers			DateSurvey Completed:			
	at the workshop.				8/22/16 ProviderIdentification Number:			
	at the workshop.				15G579	<i>7</i> 1.		
	Findings include:				SurveyEvent ID: IZSH11			
					Finding: W249— the facility			
					failed to address client			
		able incident reports were			#4'sidentified need of physical			
		6 at 12:44pm. The facility's			aggression toward peers at the			
		reports indicated the following			workshop			
	(Not all inclusive):							
	(/20/2(!!W/l- ar. [-1	: #41: 4 4			Whatcorrective action(s) will	be		
	_	ient #4] arrived at the			accomplished for these			
		residential staff reported that threatening peers at his group			residents found to havebeen			
	-	client #4] was holding up his			affected by the deficient			
	_	reatening his peers. [Client #4]			practice?			
	_	hair and chased a male peer			·Client #4 has been provided	da		
		m. Staff redirected [client #4]			cot atworkshop			
	_	ilm down. [Client #4] was			·BSP will be reviewed with workshop staffto ensure			
		nis peers. At 9:00am (sic)			understanding of and complian	nce		
		s chair and ran toward a male			with BSP	100		
		hit him. [Client #4] did not			·QIDP will review BSP's with	1		
		equested to stop. [Client #4]			workshopstaff as revisions are			
	started flailing his a	rms at staff. Staff ran and			made to ensure compliance w			
	_	etting to other clients. [Client			BSP			
	_	back to his chair to calm.			·QIDP will ensure cots are			
		s chair holding his head and			available atworkshop if BSP			
	_	lead hurting. He was given			indicates redirection to			
		t 9:55am [client #4] was			consumer's room to calm			
	_	ay from his peers when he			Howwill you identify other			
		is fist at peers and verbally			residents having the potentia	ai		
		Then he jumped up out of his			to be affected by thesame			
	Laboir and ran taxyar	d a mala near who was doing			deficient practice and what		i	

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 $IZSH11 \qquad \text{Facility ID:} \quad 001093 \qquad \qquad \text{If continuation sheet} \qquad \text{Page 9 of 14}$

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> COMPLETE			ETED	
		15G579	B. W	ING		08/22/2016	
				CEDEFE	ADDRESS OVEN STATE JID CODE		
NAME OF P	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
					NNY DR		
MCSHEF	RR INC - NEW CAS	ILE		NEW C	ASTLE, IN 47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	an activity and slap	ped him on the face with his			corrective action will be		
	open hand which ca	ased his peer to fall down.			taken?		
	Staff ran after [client #4] and tried to stop him				·All consumers with a BSP for	or	
	before he got to the	peer. Staff could not catch			physicalaggression have the		
	him in time before	he got to the male peer. [Client			potential to be affected.		
	#4] did not stop wh	en staff requested him to stop.			·BSP's that address physica		
	[Client #4] was red	irected back to his chair away			aggressiontoward peers will be		
	from his peers to calm." 6/30/16- "Shortly after [client #4] arrived at the workshop he was sitting in his chair at his table				reviewed with workshop staff t	0	
					ensure understanding ofand		
					compliance with BSP ·QIDP will review BSP's tha	.	
					address physical aggression		
	and his DSP (Direct Support Professional) was				toward peerswith workshop sta	off	
	talking to residential staff to communicate at drop				as revisions are made to ensu		
	off time. DSP turned around when another client				compliance with BSP	.	
	1 -	at [client #4] had gotten up			· QIDP will ensure cots are		
		nad a peer up against the wall			available atworkshop if BSP		
	and was biting his l	eft wrist."			indicates redirection to		
	Cliant #41a record w	vas reviewed on 8/18/16 at			consumer's room to calm		
		s undated BSP (Behavior					
	_	ated client #4 had targeted					
		al aggression, verbal					
		y abuse, non cooperation, and			Whatmeasures will be put in	to	
		ent #1's BSP indicated staff			place or what systemic		
		e following steps if client #4 is			changes you will make		
		ve "1. Move away or move the			toensure that the deficient		
		[client #4]. 2. If aggression			practice does not recur?	,	
	I	lem resolution the same as for			·QIDP will add verbiage on E		
		3. If aggression continues			ensuringitems are available at workshop to comply with BSP		
		nd tell [client #4] to go to his			physical aggression	101	
	bedroom to relax.	4. If he does not go to his			·Documentation of training		
	bedroom, continue	to calmly encourage him to go			withworkshop staff on BSP's for	or	
	and walk with him	to his room. Ask him to lay			physical aggression will includ		
	(sic) on his bed and	relax. 5. Be aware of the			list of itemsneeded to ensure		
	potential for proper	ty misuse/destruction and			compliance with plan.		
		lures if needed. 6. If he stays			HM,QIDP, and HSC observation	ons	
	in his bedroom che	ck in on him in about 10			at workshop will include		
	minutes."				determining if items areavailat	ole	
					at workshop to ensure		
	An interview with t				compliance with BSP		
	Administrator), the	Social Service Coordinator,					

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

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AND PLAN OF CORRECTION AND STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G579		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/22/2016	
	PROVIDER OR SUPPLIER RR INC - NEW CASTLE	496 DE	STREET ADDRESS, CITY, STATE, ZIP CODE 496 DENNY DR NEW CASTLE, IN 47362		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) the QIDP (Qualified Intellectual Disabilities	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	Professional) and the CEO (Chief Executive Officer) was conducted on 8/18/16 at 2:30pm. When asked how client #4's DSP should redirect his aggressive behavior at the workshop, the QIDP stated "They should follow his plan." When asked how they can follow his plan when his plan indicated he should be redirected to his room, the QIDP stated "They should be offering him a cot to lay on, we just discussed that." 9-3-4(a)		How will the corrective action(s) bemonitored to ensure the deficient practice will not recur (quality assuranceprogram, etc.) and how will it be put into place? ·QIDP will add verbiage on the ensuring tems are available at workshop to comply with BSP physical aggression ·Documentation of training withworkshop staff on BSP's for physical aggression will include list of itemsneeded to ensure compliance with plan. ·HM, QIDP, and HSC observations atworkshop will include determining if items are available at workshop to ensure compliance with BSP ·IDT will monitor through quarterlyreview Whatis the date by which the systemic changes will be completed? 9/21/16 Respectfully Submitted, Rosemary Taylor, Residential Administrator	assP for or de	

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Event ID:

IZSH11

Facility ID: 001093

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	AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G579		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/22/2016	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 496 DENNY DR NEW CASTLE, IN 47362			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE	
W 0263 Bldg. 00	PROGRAM MONITORING & CHANGE		W 0263	Nameand Address of Provide McSherr, Inc., 496Denney D	07/21/2010	
HRC (Human Rights Committee) to assure client #1's restrictive prowas conducted only with the writinformed consent of the client. Findings include: Client #1's record was reviewed of 8/17/16 at 12:15pm. Client #1's 8 BSP (Behavior Support Plan) ind		ights Committee) failed f1's restrictive program nly with the written t of the client. d was reviewed on pm. Client #1's 8/4/15		New Castle, IN DateSurvey Completed: 8/22/16 ProviderIdentification Numl 15G579 SurveyEvent ID: IZSH11 Finding: W263— The facilit HRC (Human Rights Committee)failed to assure of #1's restrictive program was conducted only with thewritte informed consent of the client	y's slient	
	aggression, obsc gestures, and lea #1's BSP indicate Stratterra and In- controlling behar Client #1's 5/16/ indicated client # consent for his B #1's annual approagency obtained their HRC on 6/8	vega to assist with viors. 16 annual approval form #1 gave written informed BSP on 7/5/16. Client oval form indicated the written approval from		Whatcorrective action(s) will accomplished for these residents found to havebee affected by the deficient practice? In the future, Client #1's signature indicating informed consent for a Behavior Supp Plan (BSP) will be obtained by getting written approval from Human Rights Committee Howwill you identify other residents having the potent to be affected by the same deficient practice and what corrective action will be taken? Allconsumers with a Beha	ort efore the	

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	ETED
		15G579	B. WI	NG	<u> </u>	08/22/2016	
				CTDEET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	1					
					NNY DR		
MCSHER	RR INC - NEW CAS	ILE		NEW C	ASTLE, IN 47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Administrator), 1	the Social Service			Support Plan (BSP) have the		
	· · ·				potential to be affected.		
	Coordinator, and the CEO (Chief Executive Officer) was conducted on				·McSherrQIDP or Designee	will	
		*			ensure written Informed conse	nt	
	•	m. When asked if the			from clients with a BSPis		
	facility obtained	written informed			obtained prior to getting appro	val	
	consent from cli	ent #1 before obtaining			from the HRC ·McSherrSocial Services		
	approval from th	e HRC, the RA stated			Coordinator or Designee will		
	"No."				ensure client approval has		
					beengiven before obtaining		
	9-3-4(a)				approval from HRC		
	9-3-4(a)				· McSherr Social Services		
					Coordinator orDesignee will		
					monitor at quarterly HRC		
					meetings		
					Whatmeasures will be put int	:0	
					place or what systemic		
					changes you will make		
					toensure that the deficient		
					practice does not recur?	الأنما	
					McSherrQIDP or Designee		
					ensure written Informed conse from clients with a BSPis	iit.	
					obtained prior to getting appro	val	
					from the HRC	· a:	
					·McSherrSSC or Designee	will	
					ensure clientapproval has bee		
					given before obtaining approva		
					from HRC		
					·McSherr Social Services		
					Coordinator orDesignee will		
					monitor at quarterly HRC		
					meetings		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G579 NAME OF PROVIDER OR SUPPLIER			A. BUII B. WIN	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 496 DENNY DR				
MCSHERR INC - NEW CASTLE				NEW CASTLE, IN 47362				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)		TE	(X5) COMPLETION DATE	
					Howwill the corrective action be monitored to ensure the deficient practicewill not rect (quality assurance program, etc.) and how will it be put intoplace? 'McSherrQIDP or Designee monitor as new BSP's are put place 'McSherrSSC or Designee with monitor as approval is request and at quarterly HRCmeetings	will into		
					Whatis the date by which the systemic changes will be completed? 9/21/16 RespectfullySubmitted, RosemaryTaylor, Residential Administrator			

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