

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G586		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/27/2012	
NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904			
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W0000	<p>This visit was for the investigation of complaint #IN00102677.</p> <p>Complaint #IN00102677: Substantiated. Federal and state deficiencies related to the allegation(s) are cited at W149, W153, W189 and W249.</p> <p>Dates of survey: January 25, 26 and 27, 2012.</p> <p>Facility Number: 001100 Provider Number: 15G586 AIM Number: 100240050</p> <p>Surveyor: Susan Reichert, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed on 2/06/2012 by Dotty Walton, Medical Surveyor III.</p>	W0000					

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

TITLE

(X6) DATE

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

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W0149	<p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on record review and interview, the facility neglected to implement their policy and procedures to protect 1 of 4 sampled clients (client A) from the use of an unapproved restraint, failed to immediately report an allegation of potential abuse and neglect, and failed to ensure staff were trained to implement plans as written.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and internal incident reports were reviewed on 1/25/12 at 4:20 PM and included the following report involving client A:</p> <p>-A report dated 1/16/12 indicated client A had recently been moved from her old room into a new bedroom and on 1/16/12 at 3:00 AM went back to her old room and "attacked" another client (unidentified). Staff #11 attempted to prevent client A from hurting the other client. Client A then attacked staff #11 and attempted to bite her. Staff # 11 "grabbed one or both of [client A's] ankles and pulled her away from the other</p>	W0149	<p>The agency will continue to follow it's policy for abuse/neglect. The QDDP will thoroughly investigate and document injuries due to abuse/neglect. The QDDP will notify the Director of Residential Services and the VP of Residential Services of any abuse/neglect incidents. Staff were retrained on the abuse/neglect policy at the Darby staff meeting on 1/25/12. Further training will also take place at the Darby staff meeting 2/22/12. House Managers will meet with all new staff to train them on each consumers behavior plan, choke plan, etc. At least bi-yearly consumer plans will be discussed in staff meetings to keep the information current for staff. Director of Residential Services, QDDP, and House Managers will ensure all staff are trained and kept current on CPI techniques. Whenever CPI holds are used as part of a behavioral intervention the staff involved will review the consumers behavior plan with the QDDP and review CPI techniques. We track for patterns and in this particular instance, Client A was moved to a new bedroom for unknown reasons. Client A does not handle change well which led to the attack on another consumer. Client A was returned to original bedroom the</p>	02/22/2012			

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	<p>consumer." The report indicated staff #11 was suspended pending the outcome of the investigation. The report did not indicate if clients were injured during the incident. An attached statement by staff #11 indicated staff #11 had "grabbed her [client A] tennis shoes and tried to pull her from the room" after client A had become physically aggressive to client H and staff #11. The attached statement from staff #10 dated 1/17/12 indicated staff #11 had grabbed client A's ankles and dragged her from her old bedroom when she became physically aggressive towards client H and staff #1. "...when she [client A] stood up, that's when I saw that [client A's] back was red above where her pants were...." The statement indicated staff #10 had not assisted in the incident as she was concerned it would have "made [client A's] behavior worse." When staff #10 informed staff #11 about the redness, staff #11 stated "she didn't do it."</p> <p>The Director of Residential Services (DRS) and Vice President (VP) were interviewed on 1/25/12 at 4:21 PM and indicated staff #11 had pulled client A from the room to prevent client A from harming the other consumer in the bedroom (client H). The VP indicated staff #10 had reported the incident to the house manager after 6 AM on 1/16/12</p>		next day.				

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	<p>after the end of the shift staff #10 and #11 had worked together. The VP indicated staff were to report allegations of abuse and neglect immediately, and client A's behavior plan had not been implemented correctly, and did not include pulling her by her ankles.</p> <p>The House Manager was interviewed on 1/25/12 at 5:31 PM and stated, "It was a bad situation," and indicated both staff working that shift were new to the group home. When asked if staff #11 had been trained, she stated, "No, she hadn't been trained in CPI (Crisis Prevention Intervention)," and when asked about training specific to client A's behavior plan stated, "All staff read their books." She indicated staff #11 had read through the client's records in the home and there was no documentation of staff #11's training in client A's behavior plan. The House Manager indicated staff #11 had schedule conflicts that had prevented her from participating in CPI training.</p> <p>The investigation into the incident dated 1/20/12 was reviewed on 1/26/12 at 10:20 AM and indicated client A "was not harmed and received no injuries during this incident," and indicated no other persons were injured as a result of the incident. The results indicated staff #10 was retrained to immediately notify the</p>						

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	<p>supervisor of any suspicion of abuse/neglect, and staff #11 had resigned. Recommendations included retrain all staff on agency abuse/neglect policy, reporting procedures and client A's behavior plan.</p> <p>The agency's policy Neglect, Battery and Exploitation of Individuals (reviewed 1/26/12 10:30 AM) dated 3/08 indicated "the agency has in effect the following policy prohibiting neglect, batter, exploitation of individuals, or psychological abuse by agency staff or outside persons...." The policy indicated "It is the responsibility of any employee who possesses knowledge of an alleged case of neglect, battery, exploitation or violation of individual rights to report it immediately, verbally and/or in writing to the President or, if the President is unavailable, the Director, Human Resources."</p> <p>This federal tag relates to complaint #IN00102677.</p> <p>9-3-2(a)</p>						

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W0153	<p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview, the facility failed to report 1 of 1 allegation of potential abuse and neglect reviewed involving client A immediately to the administrator or designee.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and internal incident reports were reviewed on 1/25/12 at 4:20 PM and included the following report involving client A:</p> <p>-A report dated 1/16/12 indicated client A had recently been moved from her old room to a new bedroom and on 1/16/12 at 3:00 AM went back to her old room and "attacked" another client (unidentified). Staff #11 attempted to prevent client A from hurting the other client. Client A then attacked staff #11 and attempted to bite her. Staff # 11 "grabbed one or both of [client A's] ankles and pulled her away from the other consumer."</p> <p>The Director of Residential Services</p>	W0153	<p>During the investigation, staff were reminded that they must immediately report any allegations of abuse/neglect to supervisors. Staff #11 was put on suspension during the investigation per agency policy. Staff #11 later terminated employment with Bona Vista due to the suspension/investigation. Direct Care Staff were retrained on 1/25/12 that they are to notify a supervisor immediately when injury is discovered. Further training will also take place at the Darby staff meeting 2/22/12.</p>	02/22/2012			

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	<p>(DRS) and Vice President (VP) were interviewed on 1/25/12 at 4:21 PM. The VP indicated staff #10 had reported the incident to the house manager after 6 AM on 1/16/12 after the end of the shift staff #10 and #11 had worked together. The VP indicated staff were to report allegations of abuse and neglect immediately.</p> <p>This federal tag relates to complaint #IN00102677.</p> <p>9-3-2(a)</p>			
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W0189	<p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on record review and interview, the facility failed to ensure staff were trained to implement plans as written for 1 of 4 sampled clients (client A).</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and internal incident reports were reviewed on 1/25/12 at 4:20 PM and included the following report involving client A:</p> <p>-A report dated 1/16/12 indicated client A had recently been moved from her old room into a new bedroom and on 1/16/12 at 3:00 AM client A went back to her old room and "attacked" another client (unidentified). Staff #11 attempted to prevent client A from hurting the other client. Client A then attacked staff #11 and attempted to bite her. Staff # 11 "grabbed one or both of [client A's] ankles and pulled her away from the other consumer." An attached statement dated 1/17/12 from staff #11 indicated client A had been redirected from her old bedroom one time that evening prior to becoming physically aggressive towards client H and staff #11. The attached statement</p>	W0189	<p>New employees, upon being hired as residential staff, complete a 3 day agency orientation. This includes such things as BDDS reporting, Disabilities Awareness, agency policies/procedures, etc. There are 3 additional trainings new hires must attend. They are CPI, CPR/FA and Med Class. Director of Residential Services, QDDP and House Managers will ensure all staff are trained and kept current on all of these trainings. A more efficient tracking system will be put in place to ensure staff do not fall through the cracks. Staff are to be trained within the first 90 days of hire. Untrained staff are not left alone with consumers.</p>	02/29/2012			

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	<p>from staff #10 dated 1/17/12 indicated staff #11 had grabbed client A's ankles and dragged her from her old bedroom when she became physically aggressive towards client H and staff #1. "...when she [client A] stood up, that's when I saw that [client A's] back was red above where her pants were...." The statement indicated staff #10 had not assisted in the incident as she was concerned it would have "made [client A's] behavior worse." When staff #10 informed staff #11 about the redness, staff #11 stated "she didn't do it."</p> <p>The Director of Residential Services (DRS) and Vice President (VP) were interviewed on 1/25/12 at 4:21 PM and indicated staff #11 had pulled client A from the room to prevent client A from harming the other consumer in the bedroom. The VP indicated client A's behavior plan had not been implemented correctly.</p> <p>The House Manager (HM) was interviewed on 1/25/12 at 5:31 PM and stated, "It was a bad situation," and indicated both staff working that shift were new to the group home. When asked if staff #11 had been trained, she stated, "No, she hadn't been trained in CPI (Crisis Prevention Intervention)," and when asked about training specific to</p>						

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	<p>client A's behavior plan, the HM stated, "All staff read their books." The HM indicated staff #11 had read through the client's records in the home and there was no documentation of staff #11's training in behavior plans. The HM indicated staff #11 had schedule conflicts that had prevented her from participating in CPI training. She indicated staff could work with clients prior to being fully trained, but were not to work alone with clients until fully trained.</p> <p>Client A's record at the group home was reviewed on 1/25/12 at 5:30 PM. Her Behavior Support Plan dated 9/11 indicated "If [client A] progresses past the agitation stage and becomes aggressive toward staff and/or other consumers follow this procedure:</p> <ol style="list-style-type: none"> 1. The protection and safety of the other consumers becomes the top priority. 2. Attempt to calm [client A] by engaging her verbally. 3. Attempt to guide [client A] to one of the bathrooms or her bedroom without using any physical intervention with the exception of lightly touching her arm or hand as a means to steer her in that direction. 4. If she chooses at this point to go to the bathroom or her bedroom, close the door and one staff member will remain immediately outside the door. 			
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	<p>5. If she refuses to move of her own volition to one of these rooms, continue to act as a barrier between her and other consumers without using any physical intervention.</p> <p>CRISIS INTERVENTION: If the above procedures are implemented, there should be no need for crisis intervention. Our aim is to motivate [client A] in a positive manner...Always use the least restrictive blocking before using the more restrictive holds. At any time during the above procedure, if [client A] becomes violently aggressive, staff may at team leader's direction (the most experienced staff present, or the staff with the most positive rapport with [client A]) begin using CPI. Only as a last resort may staff use the two person CPI hold or the 2 person CPI escort to remove [client A] from the area."</p> <p>The investigation into the incident dated 1/20/12 was reviewed on 1/26/12 at 10:20 AM. The results indicated staff #10 was retrained to immediately notify the supervisor of any suspicion of abuse/neglect, and staff #11 had resigned. Recommendations included retrain all staff on agency abuse/neglect policy, reporting procedures and client A's behavior plan.</p> <p>The agency's personnel training records</p>				

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	<p>were reviewed on 1/26/12 at 10:20 AM and failed to include evidence staff #11 was trained in CPI or regarding client A's behavior plan. There was no evidence staff #3, #8 and #12 currently working in the home were trained on client A's behavior plan.</p> <p>The agency's policy regarding staff training dated 10/10 was reviewed on 1/27/12 at 12:09 PM and indicated the agency "will train all employees or agents, at agency orientation and annually thereafter, in the protection of an individual's rights, including how to...Protect an individual from abuse, neglect and exploitation; implement person-centered planning and an individual's ISP (individual support plan)...emotional and physical crises... [Agency name] will complete all of these trainings prior to the employee or agent working with the person being served..."</p> <p>The Vice President was interviewed on 1/27/12 at 12:10 PM and indicated the agency policy regarding training was still in effect and staff were to be trained prior to working with clients.</p> <p>This federal tag relates to complaint #IN00102677.</p> <p>9-3-3(a)</p>						

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W0249	<p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on record review and interview, the facility failed to ensure staff implemented the behavior plan as written for 1 of 4 sampled clients (client A).</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and internal incident reports were reviewed on 1/25/12 at 4:20 PM and included the following report involving client A:</p> <p>-A report dated 1/16/12 indicated client A had recently been moved from her old room into a new bedroom and on 1/16/12 at 3:00 AM client A went back to her old room and "attacked" another client (unidentified). Staff #11 attempted to prevent client A from hurting the other client. Client A then attacked staff #11 and attempted to bite her. Staff # 11 "grabbed one or both of [client A's] ankles and pulled her away from the other consumer." An attached statement dated 1/17/12 from staff #11 indicated client A</p>	W0249	Client A's behavior issues/plan were discussed with staff in the Darby staff meeting jon 1/25/12. During the meeting, it was discussed the importance of using proper CPI techniques such as de-escalation for least restrictive model. These issues will again be addressed at the next Darby staff meeting on 2/22/12. House Managers will meet with all new staff to train them on each consumers behavior plan, choke plan, etc. At least bi-yearly consumer plans will be discussed/retrained in staff meetings to keep the information current for staff. Consumer binders with IPP, behavior plans, programs, etc are kept in the house office for easy reference at any time.	02/22/2012			

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	<p>had been redirected from her old bedroom one time that evening prior to becoming physically aggressive towards client H and staff #11. The attached statement from staff #10 dated 1/17/12 indicated staff #11 had grabbed client A's ankles and dragged her from her old bedroom when she became physically aggressive towards client H and staff #1. "...when she [client A] stood up, that's when I saw that [client A's] back was red above where her pants were...." The statement indicated staff #10 had not assisted in the incident as she was concerned it would have "made [client A's] behavior worse."</p> <p>The Director of Residential Services (DRS) and Vice President (VP) were interviewed on 1/25/12 at 4:21 PM and indicated staff #11 had pulled client A from the room to prevent client A from harming the other consumer in the bedroom. The VP indicated client A's behavior plan had not been implemented correctly, and staff should not have dragged client A by her ankles.</p> <p>Client A's record at the group home was reviewed on 1/25/12 at 5:30 PM. Her Behavior Support Plan dated 9/11 indicated "If [client A] progresses past the agitation stage and becomes aggressive toward staff and/or other consumers follow this procedure:</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G586		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/27/2012	
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	<p>1. The protection and safety of the other consumers becomes the top priority.</p> <p>2. Attempt to calm [client A] by engaging her verbally.</p> <p>3. Attempt to guide [client A] to one of the bathrooms or her bedroom without using any physical intervention with the exception of lightly touching her arm or hand as a means to steer her in that direction.</p> <p>4. If she chooses at this point to go to the bathroom or her bedroom, close the door and one staff member will remain immediately outside the door.</p> <p>5. If she refuses to move of her own volition to one of these rooms, continue to act as a barrier between her and other consumers without using any physical intervention.</p> <p>CRISIS INTERVENTION: If the above procedures are implemented, there should be no need for crisis intervention. Our aim is to motivate [client A] in a positive manner...Always use the least restrictive blocking before using the more restrictive holds. At any time during the above procedure, if [client A] becomes violently aggressive, staff may at team leader's direction (the most experienced staff present, or the staff with the most positive rapport with [client A]) begin using CPI. Only as a last resort may staff use the two person CPI hold or the 2 person CPI escort to remove [client A] from the</p>						

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	<p>area."</p> <p>This federal tag relates to complaint #IN00102677.</p> <p>9-3-4(a)</p>			
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