

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G802	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/29/2015
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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901
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W 0000  Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: May 19, 20, 21, and 29, 2015.</p> <p>Facility number: 012527 Provider number: 15G802 AIM number: 201024860</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0214  Bldg. 00	<p>483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN</p> <p>The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs.</p> <p>Based on record review and interview, the facility failed to complete a comprehensive behavioral assessment for 1 of 4 sampled clients (Client #2) based on identified behavioral management need.</p>	W 0214	<p><b>Toensure that Client #2 receives a comprehensive behavioral assessment, thefollowing corrective action(s) will be implemented:</b></p> <p>1) TheResidential Services</p>	06/28/2015

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

TITLE

(X6) DATE

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

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	<p>Findings include:</p> <p>On 5/21/15 at 3:29 PM, record review indicated Client #2's diagnoses included, but were not limited to, Intermittent Explosive Disorder (IED), depressive disorder, conduct disorder/adolescent onset, mood disorder, ADHD (attention deficit hyperactivity disorder), and developmental disabilities. Client #2's physician's order dated 5/1/15 to 5/31/15 indicated Client #2 was prescribed the following psychotropic medications:</p> <ul style="list-style-type: none"> <li>* Trazodone (antidepressant) 150mg (milligrams) tablet, 1 tab at bedtime.</li> <li>* Invega Sustenna 234mg/1.5ml (milliliter) shot, once every 4 weeks.</li> <li>* Clonidine (antihypertensive, used for treatment of ADHD) 0.1mg tab, 1 tab to be given at bedtime.</li> <li>* Haloperidol (antipsychotic) 10mg tablets, 3 tabs to be given at bedtime.</li> <li>* Divalproex (anticonvulsant, prescribed for mood) ER (extended release) 500mg tablets, 3 tabs to be given at bedtime.</li> <li>* Oxcarbazepine (anticonvulsant prescribed for mood stabilization) 600mg</li> </ul>		<p>Department Qualified Intellectual Disabilities Professional (QIDP) will contact an agency Behavioral Consultant to schedule a comprehensive behavioral assessment. The Behavior Consultant will submit a report that will include how the assessment was conducted and the findings. The report will then be reviewed by the inter-disciplinary (IDT) team to determine the appropriate course of action to address the behavioral needs of the client.</p> <p>2) Once all needs have been identified and plans have been created to address the behavioral needs, the QIDP will update Client #2's behavioral support plan.</p> <p>3) All staff located at 112 East Westmoreland (Westmoreland group home) will be trained on the revised behavioral support plan for Client #2. Completed Record of Trainings will be obtained and submitted upon completion of training. <i>Refer to Appendix A for Record of Training form to be used.</i></p>	

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	<p>tablet, 1 tab 3 times a day.</p> <p>* Guanfacine (prescribed for the treatment of ADHD) 1mg ER (extended release) tablet, 1 tab to be given in the morning.</p> <p>* Seroquel (antipsychotic) XR (extended release) 400mg tablet, 1 tablet to be given in the evening.</p> <p>* Benztropine (Cogentin, used for the treatment of the side effects of psychotropic medications) 1mg tablet, 1 tablet twice daily.</p> <p>* Haloperidol (antipsychotic) 5mg tablet, 1 tab every 6 hours PRN (given as needed).</p> <p>Record review indicated Client #2's ISP (Individual Support Plan) dated 7/18/14 included a BSP (Behavior Support Plan) dated 7/18/14. Client #2's BSP indicated the target behaviors of verbal abuse, elopement, physical aggression, property destruction, resists supervision, calling 911 (emergency phone number), false accusations, pulling hair, self-injurious behavior, suicidal ideation/attempt, spitting, fecal smearing, and removal of clothing. Client #2's BSP indicated "[Client #2]'s behavior includes spitting on others, pulling hair, fecal smearing,</p>		<p>4) Thebehavior assessment will be reviewed annually by the inter-disciplinary team toensure that Client #2's specific developmental and behavioral needs areappropriately being met.</p>				

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	<p>destruction of property at home or in the community, removal of clothing at home or in the community, calling 911 for non-emergencies, making false accusations, verbal and physical aggression, and running away. When his behavior is engaged by others it escalates in severity. He has a history of responding inappropriately to authority and in public. He acts out towards law enforcement. He frequently verbalizes suicidal ideation and has made superficial attempts to harm himself. [Client #2] is to always have 2 on 1 staffing. He is never to be out in the community or at home with just 1 staff. [Client #2] has a history of having physical aggression in a vehicle while there was only the driver in the car. This is a serious situation and could lead to great harm. For [Client #2]'s safety and welfare there will always be the 2 staff with him to ensure his health and safety."</p> <p>Record review indicated Client #2 had no comprehensive behavior assessment.</p> <p>On 5/21/15 at 5:21 PM during an interview, the facility Administrator indicated Client #2's BSP was written by her when she was the group home's QIDP (Qualified Intellectual Disabilities Professional). The Administrator indicated Client #2 would benefit from a</p>			

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W 0323 Bldg. 00	<p>comprehensive behavior assessment.</p> <p>9-3-4(a)</p> <p>483.460(a)(3)(i) PHYSICIAN SERVICES 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, the facility failed to ensure an eye exam was completed annually as recommended by the ophthalmologist for 1 of 4 sampled clients (#4).</p>	W 0323	<p><b>To ensure the completion of all necessary and required assessments for Client #4, the following corrective action(s) will be implemented:</b></p> <p>1) The Residential Nurse will schedule a vision exam</p>	06/28/2015

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	<p>Findings include:</p> <p>On 5/21/15 at 5:01 PM, Client #4's record review indicated diagnoses which included, but were not limited to, moderate intellectual disabilities, bipolar disorder, generalized anxiety disorder, borderline personality disorder, and choroidal (vascular layer of the eye) scarring.</p> <p>Record review indicated Client #4 had an eye exam dated 10/28/13. The eye exam indicated "Choroidal scarring as designated on image. Defined edges without elevation/vascularization." The medical form indicated "Discussed risk and importance of annual re-evaluation." Record review indicated Client #4 had no eye exam since 10/28/13 in the record.</p> <p>On 5/29/15 at 5:10 PM during an interview, the facility Administrator indicated Client #4 did not have a more current vision exam than the exam dated 10/28/13. The Administrator indicated Client #4 did not receive an annual re-evaluation as recommended likely due to oversight.</p> <p>9-3-6(a)</p>		<p>for Client #4. Upon completion,documentation of the appointment will be maintained in the client file withinthe group home.</p> <p>2) Toensure that appointments are scheduled and completed as required or directed byphysicians, the Residential Quality Assurance Coordinator will review clientfiles on a quarterly basis. In the eventthat an appointment is needed and has not been conducted, the Residential Nursewill be notified to schedule the appointment. The Director and Vice Presidentof Residential Services will also be notified for monitoring purposes to ensurethat the appointment was scheduled, conducted, and documented.</p>		

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W 0368  Bldg. 00	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>Based on record review and interview, the facility failed to ensure medications were administered as prescribed by physician's orders for 3 of 4 sampled clients (#1, #2, and #4) and 2 additional clients (#6, #8).</p> <p>Findings include:</p> <p>On 5/20/15 at 3:38PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 2/20/15 to 5/20/15 were reviewed. A BDDS report dated 3/12/15 indicated "On 3/11/15, a direct support professional was passing 8pm medications, when they realized that [Client #2] had been given another consumer's medications the night before. [Client #2] received 500mg of Depakote (anticonvulsant), 3mg Risperdal (antipsychotic), 1mg of Benztropine (generic for Cogentin, used to prevent side effects from antipsychotic medications), and 5mg Olanzapine (antipsychotic) in addition to his other 8pm medication on 3/10/15. The direct support professional immediately</p>	W 0368	<p><b>To ensure that all medications are administered as prescribed by physicians' orders and without error, the following corrective action(s) will be implemented:</b></p> <p>1) All staff located at 112 East Westmoreland Drive (Westmoreland group home) will receive re-training on the agency medication administration policy. Completed Record of Trainings will be obtained and submitted upon completion of training. <i>Refer to Appendix B for Record of Training forms to be used.</i> It is the intent that this training will prevent future medication errors for the clients affected as well as all other clients residing in the home.</p> <p>2) To consistently monitor medication administration and to ensure competency and compliance, all Residential Nurses will be required to</p>	06/28/2015			

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	<p>contacted the residential house manager and on-call nurse on 3/11/15. The on-call nurse contacted the charge nurse at [regional health facility] who spoke to [physician], the on-call psychiatrist. [Physician] ordered for staff to 'observe' [Client #2] and continue normal dosing. [Client #2] has not shown any adverse side effects from the additional medication."</p> <p>A BDDS report dated 4/3/15 indicated "On 4/2/15, it was reported to this author that [Client #8] did not receive his 8pm medications of Depakote (antiseizure) 500mg, Risperdal (antipsychotic) 3mg, Olanzapine (atypical antipsychotic) 3.5mg, or Benztropine (generic for Cogentin, used to prevent side effects of psychotropic medications) 1mg. Direct Support Professional contacted the Residential Nurse. Residential Nurse left a message for the on-call doctor at [behavioral health facility] and contacted the Residential QIDP (Qualified Intellectual Disabilities Professional). Staff will observe [Client #8] and continue normal dosing a (sic) unless otherwise directed by [behavioral health facility]."</p> <p>A BDDS (Bureau of Developmental Disabilities Services) report dated 4/17/15 indicated "Direct Support</p>		<p>conduct weekly reviews of all medication records for all clients residing in the home. Additionally, they will observe staff on a routine basis to ensure that all medications are administered according to physician's orders and agency policy. In the event of a medication error, the Residential Nurse will immediately review all medication records for all clients residing in the home, not just those that are affected, to ensure that no other medication errors have occurred, that staff fully comprehend and understand directives for medication administration as stated on the MAR (medication administration record), and that medications are being administered according to physician's orders and agency policy.</p>	

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	<p>Professionals did not administer [Client #4]'s 8am Metformin (used as treatment for type 2 diabetes) 250mg (milligrams) on 4/16/15. He received all other 8am medications. The residential nurse discovered the missed dosage at his 8pm medication pass." The report indicated "The Direct Support Professional was counseled per Bona Vista's medication policy and retrained on passing the medication on 4/16/15. Metformin was prescribed on 4/15/15 by [physician], a doctor at [urgent care], to help control his high blood sugar level. [Client #4] did not experience any side effects from not taking the 8am dosage."</p> <p>A BDDS report dated 5/9/15 indicated "Direct support professional administered [Client #6]'s medication Clonazepam (antidepressant) 1mg tab at 8pm on 5/08/2015 accidentally. Doctor was notified. [Client #6] has had no adverse side effects from getting this medication last evening and will continue to be monitored."</p> <p>A BDDS report dated 5/26/15 indicated "[Client #6]'s [psychiatric nurse] failed to discontinue his previous order for Haloperidol (antipsychotic) and both his old and new prescriptions were put in the same medication packaging on 5/23/15. Staff administered an extra 5mg tablet at</p>			

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	<p>each medication pass on 5/23/15 and 5/24/15 for a total of an extra 20mg per day. Residential House Manager caught the error on 5/25/15 and notified the on-call nurse. The on-call nurse gave the house manager instructions to remove the excess medication from the packaging so it would not be given again. Doctor was notified. A nurse did an evaluation and confirmed that [Client #6] was not having any adverse side effects from the extra dose."</p> <p>A BDDS report dated 5/27/15 indicated "Direct Support Professional did not administer [Client #1]'s 8am Paroxetine (antidepressant) 30mg. All other 8am medications were administered. The residential nurse was contacted ...". The report indicated "[Client #1] had no side effects from the missed medication."</p> <p>On 5/21/15 at 5:21 PM, the facility administrator indicated staff are expected to administer medications without error.</p> <p>9-3-6(a)</p>			