STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G802	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONA VISTA PROGRAMS INC	112 E WESTMORELAND KOKOMO, IN 46901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
W0000	This visit was for an annual fundamental recertification and state licensure survey. This visit included the investigation of complaint #IN00103114. Complaint #IN00103114: Unsubstantiated-lack of evidence Dates of Survey: February 7, 8, 9, and 10, 2012 Facility number: 012527 Provider number: 15G802 AIM number: 201024860 Surveyor: Tracy Brumbaugh, Medical Surveyor III These deficiencies also reflect state findings under 460 IAC 9. Quality review completed on 2/16/2012 by Dotty Walton, Medical Surveyor III.	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement 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 AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G802	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONA VISTA PROGRAMS INC	112 E WESTMORELAND KOKOMO, IN 46901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
W0104	The governing body must exercise general policy, budget, and operating direction over the facility.			
	Based on observation and interview, the facility failed for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7, and #8) who lived in the home, to ensure the bathroom was in good repair. Findings include: On 2-7-12 from 3:30 p.m. until 5:00 p.m. an observation at the home of clients #1, #2, #3, #4, #5, #6, #7, and #8 was conducted. The bathroom had peeled and bubbled paint around the shower on the wall in a 2 foot by 2 foot area and 3 places on the ceiling 4 inches by 6 inches. The blue recliner downstairs had the wooden leg on the left side broken off. On 2-8-12 at 1:30 p.m. an interview with the Qualified Mental Retardation Professional indicated the ceiling and walls were in need of repair in the bathroom, the recliner was broken and there was no other documentation available for review. 9-3-1(a)	W0104	The bathroomwall around the shower was repaired and painted on 02/13/2012. It was determined that the blue recliner wasnot able to be repaired, so it was removed from the house. The QDDP and House Manager will monitor the house for repairs and send maintenance requests as needed. The maint. requests will be submitted electronically so that they can be tracked by the submitting department and also the maintenance department.	02/13/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G802	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONA VISTA PROGRAMS INC	112 E WESTMORELAND KOKOMO, IN 46901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
W0149	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, the facility failed for 1 of 4 sampled clients (client #2) to ensure the facility's Abuse/Neglect/Exploitation Policy was implemented for 1 of 34 Bureau of Developmental Disability (BDDS) reports. Findings include: On 2-7-12 at 9:00 a.m. a review of the facility's Bureau of Developmental Disability (BDDS) reports was conducted. The BDDS reports indicated the following: -A BDDS report with an incident date of 12-30-11 and a submit date of 1-3-12 for client #2 indicated direct care staff (dcs) #25 had made inappropriate comments "Why don't you come over on this, you know you want me," to client #2. Direct care staff #20 reported dcs #25 for the inappropriate comments. On 2-7-12 at 10:15 a.m. a review of the facility's Abuse/Neglect/Exploitation Policy dated 5-11 was conducted. The policy indicated abuse/neglect/exploitation was prohibited by agency staff.	W0149	The staff that made the comments to client #2 was immediately terminated following the investigation per agency policy. Abuse, neglect and exploitation issues were discussed at the staff meetings on 01/12/2012,01/26/2012 & 02/09/2012 (with the last meeting on the 9 th being the first meeting after the inspection while the other two were just after the incident itself). They included what types of comments, like the one at issue in this incident, were inappropriate and considered abuse, neglect and/or exploitation and that any such comments or actions by staff must be reported immediately to the house manager and/or QDDP no matter what time during day or night they were discovered. Client #2 has weekly counseling with the behaviorist/counselor about appropriate adult interactions. The QDDP has frequent one on one sessions with client #2 to build trust and see the Q as someone to come to if staff are not treating him appropriately.	02/13/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G802	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONA VISTA PROGRAMS INC	112 E WESTMORELAND KOKOMO, IN 46901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	On 2-8-12 at 1:30 p.m. an interview with the Qualified Mental Retardation Professional indicated dcs #25 should not have made inappropriate comments to client #2 and staff #25 did not follow their policy which prohibited abuse/neglect/exploitation. 9-3-2(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G802	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONA VISTA PROGRAMS INC	112 E WESTMORELAND KOKOMO, IN 46901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
W0153	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, the facility failed for 1 of 4 sampled clients (client #2) to ensure an allegation of mistreatment was reported immediately for 1 of 34 Bureau of Developmental Disability (BDDS) reports reviewed. Findings include: On 2-7-12 at 9:00 a.m. a review of the facility's Bureau of Developmental Disability (BDDS) reports was conducted. The BDDS reports indicated the following: -A BDDS report with an incident date of 12-30-11 and a submit date of 1-3-12 for client #2 indicated direct care staff (dcs) #25 had made inappropriate comments "Why don't you come over on this, you know you want me." to client #2. Direct care staff #20 reported dcs #25 for the inappropriate comments. On 2-10-12 at 2:20 p.m. an interview with the facility's Vice President indicated BDDS reports needed to be filed within 24 hours.	W0153	The staff that made the comments to client #2 was immediately terminated following the investigation per agency policy. Abuse, neglect and exploitation issues were discussed at the staff meetings on01/12/2012,01/26/2012 & 02/09/2012. Staff were reminded at all these staff meetings that they are to report immediately to the house manager and/or QDDP no matter what timeduring day or night they were discovered. In addition, the staff were trained on the Elder Justice Act which is also posted in the office for all staff to read. We had mandatory annual agency wide trainings which included OSHA, abuse/neglect policy, HIPAA, universal precautions etc. Management staff phone numbers are posted in all group homes.	02/13/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G802	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONA VISTA PROGRAMS INC	112 E WESTMORELAND KOKOMO, IN 46901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	9-3-1(b)(5) 9-3-2(a)			
W0323	The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.			
	Based on record review and interview, the facility failed for 1 of 4 sampled clients (client #1) to ensure he had a hearing evaluation annually. Findings include: On 2-8-12 at 11:30 a.m. a record review for client #1 was conducted. Client #1's annual physical dated 9-20-11 did not indicate his hearing was evaluated. There was no hearing evaluation available to review. Client #1 moved into the group home on 8-5-11 according the the review of the client roster on 2-7-12 at 9:00 a.m. On 2-9-12 at 10:50 a.m. an interview with the facility's Vice President indicated there was no hearing evaluation available for review. 9-3-6(a)	W0323	Client #1 was seen by audiologist Kathryn Little, MACCC-A, on 02/22/2012 for a hearing evaluation. His ear canal was in need of cleaning before a hearing eval can be completed. Client #1 had an appointment with Primary Care Dr to remove excessive amounts of ear wax out of his ear canals. Client #1 hearing eval was re-scheduled for March 14. Physician statement attached. The QDDP will ensure that the clients have all necessary appointments completed within the first 30 days of moving in.	03/14/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G802	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONA VISTA PROGRAMS INC	112 E WESTMORELAND KOKOMO, IN 46901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
W0436	The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.			
	Based on observation, record review, and interview, the facility failed for 1 of 3 clients (client #4) who used adaptive equipment, to ensure he wore his prescribed glasses. Findings include: On 2-7-12 from 6:10 a.m. until 8:00 a.m. an observation at the home of client #4 was conducted. Client #4 got himself a cup of juice and a bowl of cereal and took his medications. Client #4 did not wear his glasses during this observation. On 2-7-12 at 11:15 a.m. client #4 was observed at the facility owned day program. Client #4 did a job which required him to use screws and an electric screwdriver. Client #4 did not wear his glasses while he worked. On 2-7-12 from 3:30 p.m. until 5:00 p.m. an observation at the home of client #4 was conducted. Client #4 assisted with supper preparation, watched television, served himself supper, and ate his supper. Client #4 did not wear his glasses during	W0436	Client #4 does not like to wear his glasses because they are uncomfortable. Staff will prompt client #4 to wear his glasses. Client #4 now has a glasses program which is attached. Staff are prompting client #4 to wear glasses. Client #4 chooses to wear them sometimes and not wear them but staff will prompt client daily. The QDDP will implement goals to assist clients that have adaptive equipment based on the functioning level of the clients. The Social Services Coordinator completes the Periodic Service Review to ensure that goals in place for these items. (Client #4 program attached)	02/13/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G802	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/10/2012
NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	this observation. On 2-8-12 at 1:00 p.m. a record review for client #4 was conducted. The visual exam dated 6-14-11 indicated client #4 was nearsighted and required astigmatism correction in each eye. Eye glasses were prescribed and ordered. On 2-8-12 at 1:30 p.m. an interview with the Qualified Mental Retardation Professional indicated client #4 should wear his glasses as prescribed. 9-3-7(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G802	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/10/2012
NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
W0455	There must be an active program for the prevention, control, and investigation of infection and communicable diseases.			
	Based on observation and interview, the facility failed for 2 of 4 sampled clients (clients #1 and #3) to ensure medications weren't given after falling into the trash can and to ensure staff didn't touch the medications with her bare hands. Findings include: 1. On 2-7-12 from 7:46 a.m. until 7:55 a.m. an observation of client #1's medication administration was conducted. Client #1 dropped his Trileptal (anticonvulsant) 600 milligrams (mg) in the trash can then took it back out and placed it in his mouth. Direct care staff (dcs) #2 did not prompt client #1 to not take a pill which had fallen into a trash can. 2. On 2-7-12 from 7:18 a.m. until 7:30 a.m. an observation of client #3's medication administration was conducted. Direct care staff (dcs) #2 used her bare hands to take client #3's Vitamin E (for nutrition) and Lithium Carbonate ER/extended release (for his mood) out of the bottle and handed them to him. On 2-8-12 at 1:30 p.m. an interview with the Qualified Mental Retardation	W0455	All staff has been trained by the nurse regarding medication issues. Staff was trained that at no time should staff's bare hands touch the medication. If necessary to touch medication during med administration, staff will wear gloves. If medication falls into the trash or otherwise comes out of the pre-packaged container when administering medication or falls from the dispensing cup before it reaches the clients mouth, then the medication is destroyed and another pill is given. The dropped pill is destroyed per agency policy. Staff are to follow Med Core A&B.The medication errors that occured during observation were addressed at the staff meeting held on 02/09/2012. (meeting notes attached) The House Manager and Nurse will observe random med passes to ensure staff are following procedures taught in Med Core A&B.	02/13/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G802	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONA VISTA PROGRAMS INC	112 E WESTMORELAND KOKOMO, IN 46901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	Professional indicated medications should not be given after they fell into a trash can and staff should not touch clients' medications with her bare hands. 9-3-7(a)			