

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G744	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/12/2014
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NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2453 S 100 E PERU, IN 46970
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: April 30 and May 1, 2, 5, 12, 2014.</p> <p>Facility number: 006630 Provider number: 15G744 AIM number: 200902110</p> <p>Surveyor: Amber Bloss, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 5/20/14 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.</p> <p>Based on record review and interview for 1 of 4 sampled clients (#2), the facility</p>	W000149	Toensure that established agency policies and procedures for incident reportings is being implemented	06/10/2014

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.

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	<p>failed to implement its written policies and procedures in regards to investigating injuries of unknown origin.</p> <p>Based on record review and interview for 1 of 4 sampled clients (#2), the facility failed to implement its written policies and procedures in regards to documentation that a thorough investigation was completed in regards to an allegation of staff to client verbal abuse.</p> <p>Based on record review and interview for 1 of 4 sampled clients (#4) and 1 additional client (#7), the facility failed to implement its written policies and procedures in regards to conducting an investigation of client to client abuse.</p> <p>Findings include:</p> <p>1. On 5/1/14 at 12:06 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 5/1/13 to 5/1/14 were reviewed. A BDDS report dated 6/2/13 indicated "group home staff contacted QDDP (Qualified Developmental Disabilities Professional) & reported [Client #2] was checked on at 9:15 pm & (and) was in his bed & when checked on at 9:30 pm wasn't in bed & discovered on the the bathroom floor near the toilet w/ (with) a sm. (small) 1" (inch)</p>		<p>and executed as written, the following correction actions will be implemented:</p> <p>1. All staff located at the location of 2453 South 100 East (Bobtail group home) will be re-trained on the agency Personnel Policies and Procedures, Policy III:13: Incident Reporting. 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> <p>2. All investigations will be conducted in the manner outlined on the Residential Services Investigation Process. <i>Refer to Appendix B for process outline.</i> To ensure that all investigations are conducted in a uniform and consistent manner, all Residential House Managers, Qualified Development Disability Professionals, Nurses, the Director, and the Residential Services Coordinator will be trained on the newly established investigation process outline. <i>Refer to Appendix C for Record of Training form to be used in documenting training.</i></p> <p>3. To ensure that all incidents of injury of unknown origin and peer-to-peer aggression are properly documented and investigated. Any incidents will be reported to the Residential Services Coordinator. The Residential Services Coordinator will complete the appropriate documentation and maintain for</p>				

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	<p>scratch above his right eye on his forehead. He was helped to the toilet to use the restroom & proceeded to have a seizure." The report indicated the "residential nurse was contacted & VNS (vagal nerve stimulator) magnet (used to end seizure activity) was used per Residential nurse." The report indicated "He came out of the seizure & shortly thereafter he was observed resting quietly w/ his eyes closed in his bed. Staff also informed the QDDP [Client #2] had 2 seizures earlier in the day one at 11:30 am VNS magnet used & one at 4:25 pm rectal Diastat (anticonvulsant) given & in both cases the Residential nurse was contacted."</p> <p>-The follow up BDDS report dated 6/1/13 indicated "It was determined the fall was likely caused by [Client #2] having a seizure. Staff followed [Client #2]'s seizure plan/protocol. [Client #2] has been doing well & had no additional seizures or issues/problems associated w/ (with) this incident."</p> <p>On 5/1/14 at 11:43 AM during an interview with the Director and the Vice President of Residential Services (VPR), the Director indicated there was no further documentation indicating Client #2's injury of unknown origin was investigated. The VPR indicated it was</p>		<p>recordkeeping purposes. Refer to Appendix D to review forms that will be implemented occurrences of either incident.</p> <p>4. Lastly to ensure that incidents have been reported and investigated in the manner as outlined in agency policies, all investigations packets, regardless of type, will have an investigation process checklist included. The checklist will be completed by the Residential Services Coordinator as he/she is conducting the investigation. Upon the conclusion of the investigation, all investigation materials including the checklist will be given to the Vice President of Residential Services for review. The Vice President of Residential Services will sign-off on the checklist and accompanying materials once all items have been reviewed and approved. Refer to Appendix E to review investigation process checklist.</p>				

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	<p>facility policy to investigate injury of unknown origins. The VPR indicated Client #2's injury of unknown origin should have been investigated.</p> <p>On 5/1/14 at 1:30 PM, the facility abuse/neglect policy titled "Prohibition of Violations of Individual Rights" (undated) indicated "...Bona Vista Programs strictly prohibits the abuse of any form, neglect, exploitation or mistreatment of an individual... ." The policy defined neglect as "failure to provide supervision, training, appropriate... ."</p> <p>2. On 5/1/14 at 12:06 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 5/1/13 to 5/1/14 were reviewed. A report dated 2/7/14 indicated "a consumer's family member came to visit on 2/7/14 at 6:00 am. During her visit, she reported that a staff member was yelling at a consumer to 'stand up', and using a harsh tone while assisting him in the restroom. The family member reported that she thought the consumer was [Client #1]. The allegation of abuse was unsubstantiated through internal investigation. It was determined through the investigation that the consumer in the restroom was not [Client #1] but [Client #2]. [DSP (Direct Support Professional) #8] was working</p>						

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	<p>with [Client #2] at the time of the incident. [DSP #8] was suspended during the investigation and returned to work after review of abuse and neglect policy. [DSP #8] was assigned to another home following the incident."</p> <p>-The follow up BDDS report dated 3/25/14 indicated "the accused staff was immediately suspended and an investigation was completed. All staff working in the home, including those working on the shift in question, were interviewed. No other staff reported observing any verbal abuse at that time or any other time." The report indicated "[Client #2] was also interviewed and did not indicate that he had been verbally abused at that time or any other. Staff did state to the writer that the particular bathroom that consumer [Client #2] was being given care in, is a large bathroom, that is completely tiled, and voices often 'echo' and can sound louder than they actually are spoken." The follow up report indicated "it was mentioned to writer by other staff in the home at time of incident that it was actually a fairly quiet morning and that [Client #2] was given AM care by [DSP #8] and seems to respond well when she gives him AM care." The report indicated "[DSP #8] is a loud talker and was counseled on being aware of the volume/tone of voice, just to</p>				

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	<p>make sure that she is not coming across inappropriately."</p> <p>On 5/1/14 at 1:36 PM, the investigation was reviewed. The investigation indicated Client #2's diagnoses, included but were not limited to, moderate intellectual disabilities and seizure disorder. The investigation indicated Client #2 had "limited verbal speech, speaks one to two word sentences most times." The investigation indicated "family member of another consumer was in a bedroom of another consumer when she allegedly overheard staff talking in a verbally abusive tone to another consumer in the group home bathroom when getting that consumer ready for the day." The investigation included an interview with DSP #8 which indicated DSP #8 denied the accusation of verbal abuse. The interview indicated DSP #8 "didn't sound mean or hateful, I was just reminding him that we do this and he can understand that he knows he can do it. He likes to try and get staff to think of him as a 'baby' and can't do things because I know he can and I encourage him." The investigation did not include any other interviews. The investigation did not include an interview with the family member who made the allegation or the other staff members. The investigation summary indicated "writer</p>			

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	<p>does not feel that verbal abuse can be substantiated in this case due to the feedback received from the other staff in the home at time of incident as well as the feedback from the other staff that work in the home on other shifts. Writer feels that the alleged staff member was not intentionally using loud or using a harsh tone with [Client #2]... ."</p> <p>On 5/1/14 at 11:43 AM during an interview, the Director indicated it was the facility's policy to thoroughly investigate staff to client abuse. The Director indicated there was no further documentation to indicate the investigation was thoroughly completed with documentation of each interview. The Director indicated Client #2 was not a thorough self-reporter.</p> <p>On 5/1/14 at 1:30 PM, the facility abuse/neglect policy titled "Prohibition of Violations of Individual Rights" (undated) indicated "...Bona Vista Programs strictly prohibits the abuse of any form, neglect, exploitation or mistreatment of an individual... ." The policy defined "Prohibited Practices" as "(3) Emotional/Verbal abuse including but not limited to communicating words or actions in a person's presence with an intent to: cause the individual to be in fear of retaliation; cause the individual to</p>						

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	<p>be placed in fear of confinement or restraint; cause the individual to experience emotional distress or humiliation... ."</p> <p>3. On 5/1/14 at 12:06 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 5/1/13 to 5/1/14 were reviewed. A BDDS report dated 6/17/13 was reviewed and indicated "upon entering workshop, [Client #4] struck [Client #5] in the upper back, leaving a red hand print. [Client #4] and [Client #5] were separated." The report indicated "[Client #4] was laid off for 6/17/13 and will return to work on 6/18/13. Staff will continue to monitor for safety." No further documentation was available to indicate an investigation was conducted.</p> <p>A BDDS report dated 5/16/13 indicated "while in the restroom facility, [Client #7] punched [Day Program Client (DPC) #1] in the left jaw." The report indicated "[Client #7] stated that [DPC #1] was singing and he [Client #7] didn't like it (the singing)." The report indicated a nurse "completed the body assessment noting a red mark on the left jaw of [DPC #1]." The report indicated "an ice pack was administered. [Client #7] and [DPC #1] were separated." The report indicated "[Client #7] has a BSP</p>						

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	<p>(Behavior Support Plan) in place to address verbal and physical aggression. [Client #7] was laid off for 5/16/13 per workshop policy for physical aggression." No further documentation was available to indicate an investigation was conducted.</p> <p>On 5/1/14 at 11:43 AM during an interview, the Vice President of Residential Services (VPR) indicated it was the facility's policy to investigate client to client abuse. The VPR indicated those incidents of alleged client to client abuse should have been investigated. The VPR indicated incidents which happen at the day program are investigated by the day program. The VPR indicated she knew the facility should have ensured a thorough investigation was completed.</p> <p>On 5/1/14 at 1:30 PM, the facility abuse/neglect policy titled "Prohibition of Violations of Individual Rights" (undated) indicated "...Bona Vista Programs strictly prohibits the abuse of any form, neglect, exploitation or mistreatment of an individual... ." The policy defined abuse as "intentional willful infliction of physical injury... ."</p> <p>9-3-2(a)</p>						

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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview, the facility failed to ensure a thorough investigation of an allegation of staff to client abuse for 1 of 1 incident reviewed for allegations of staff to client abuse for 1 of 4 sampled clients (#2).</p> <p>Based on record review and interview, the facility failed to ensure a thorough investigation of an allegation of client to client abuse for 1 of 1 incident reviewed for allegations of client to client abuse for 1 of 4 sampled clients (#4) and 1 additional client (#5).</p> <p>Findings include:</p> <p>On 5/1/14 at 12:06 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 5/1/13 to 5/1/14 were reviewed. A report dated</p>	W000154	<p>To ensure that investigations for BDDS reportable incidents are being conducted in a thorough and consistent manner, the following correction actions will be implemented:</p> <p>1. All investigations will be conducted in the manner outlined on the Residential Services Investigation Process. <i>Refer to Appendix B for process outline.</i> To ensure that all investigations are conducted in a uniform and consistent manner, all Residential House Managers, Qualified Development Disability Professionals, Nurses, the Director, and the Residential Services Coordinator will be trained on the newly established investigation process outline. <i>Refer to Appendix C for Record of Training form to be used in documenting training.</i></p> <p>2. To ensure that all incidents of injury of unknown origin and</p>	06/10/2014	

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	<p>2/7/14 indicated "a consumer's family member came to visit on 2/7/14 at 6:00 am. During her visit, she reported that a staff member was yelling at a consumer to 'stand up', and using a harsh tone while assisting him in the restroom. The family member reported that she thought the consumer was [Client #1]. The allegation of abuse was unsubstantiated through internal investigation. It was determined through the investigation that the consumer in the restroom was not [Client #1] but [Client #2]. [DSP (Direct Support Professional) #8] was working with [Client #2] at the time of the incident. [DSP #8] was suspended during the investigation and returned to work after review of abuse and neglect policy. [DSP #8] was assigned to another home following the incident."</p> <p>-The follow up BDDS report dated 3/25/14 indicated "the accused staff was immediately suspended and an investigation was completed. All staff working in the home, including those working on the shift in question, were interviewed. No other staff reported observing any verbal abuse at that time or any other time." The report indicated "[Client #2] was also interviewed and did not indicate that he had been verbally abused at that time or any other. Staff did state to the writer that the particular</p>		<p>peer-to-peer aggression are properly documented and investigated. Any incidents will be reported to the Residential Services Coordinator. The Residential Services Coordinator will complete the appropriate documentation and maintain for recordkeeping purposes. <i>Refer to Appendix D to review forms that will be implemented occurrences of either incident.</i></p> <p>3. To ensure that incidents have been reported and investigated in the manner as outlined in agency policies, all investigation packets, regardless of type, will have an investigation process checklist included. The checklist will be completed by the Residential Services Coordinator as he/she is conducting the investigation. Upon the conclusion of the investigation, all investigation materials including the checklist will be given to the Vice President of Residential Services for review. The Vice President of Residential Services will sign-off on the checklist and accompanying materials once all items have been reviewed and approved. <i>Refer to Appendix E to review investigation process checklist.</i></p> <p>4. All investigation materials will be maintained in a centralized location within the Residential Services department. Additionally, copies of any investigation materials involving</p>		

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	<p>bathroom that consumer [Client #2] was being given care in, is a large bathroom, that is completely tiled, and voices often 'echo' and can sound louder than they actually are spoken." The follow up report indicated "it was mentioned to writer by other staff in the home at time of incident that it was actually a fairly quiet morning and that [Client #2] was given AM care by [DSP #8] and seems to respond well when she gives him AM care." The report indicated "[DSP #8] is a loud talker and was counseled on being aware of the volume/tone of voice, just to make sure that she is not coming across inappropriately."</p> <p>On 5/1/14 at 1:36 PM, the investigation was reviewed. The investigation indicated Client #2's diagnoses, included but were not limited to, moderate intellectual disabilities and seizure disorder. The investigation indicated Client #2 had "limited verbal speech, speaks one to two word sentences most times." The investigation indicated "family member of another consumer was in a bedroom of another consumer when she allegedly overheard staff talking in a verbally abusive tone to another consumer in the group home bathroom when getting that consumer ready for the day." The investigation included an interview with DSP #8 which indicated</p>		<p>staff will also be sent to the Human Resources Department for record keeping purposes.</p>				

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	<p>DSP #8 denied the accusation of verbal abuse. The interview indicated DSP #8 "didn't sound mean or hateful, I was just reminding him that we do this and he can understand that he knows he can do it. He likes to try and get staff to think of him as a 'baby' and can't do things because I know he can and I encourage him." The investigation did not include any other interviews. The investigation did not include an interview with the family member who made the allegation or the other staff members. The investigation summary indicated "writer does not feel that verbal abuse can be substantiated in this case due to the feedback received from the other staff in the home at time of incident as well as the feedback from the other staff that work in the home on other shifts. Writer feels that the alleged staff member was not intentionally using loud or using a harsh tone with [Client #2]... ."</p> <p>On 5/1/14 at 11:43 AM during an interview, the Director indicated it was the facility's policy to thoroughly investigate staff to client abuse. The Director indicated there was no further documentation to indicate the investigation was thoroughly completed with documentation of each interview. The Director indicated Client #2 was not a thorough self-reporter.</p>						

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	<p>2. On 5/1/14 at 12:06 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 5/1/13 to 5/1/14 were reviewed. A BDDS report dated 6/17/13 was reviewed and indicated "upon entering workshop, [Client #4] struck [Client #5] in the upper back, leaving a red hand print. [Client #4] and [Client #5] were separated." The report indicated "[Client #4] was laid off for 6/17/13 and will return to work on 6/18/13. Staff will continue to monitor for safety." No further documentation was available to indicate an investigation was conducted.</p> <p>A BDDS report dated 5/16/13 indicated "while in the restroom facility, [Client #7] punched [Day Program Client (DPC) #1] in the left jaw." The report indicated "[Client #7] stated that [DPC #1] was singing and he [Client #7] didn't like it (the singing)." The report indicated a nurse "completed the body assessment noting a red mark on the left jaw of [DPC #1]." The report indicated "an ice pack was administered. [Client #7] and [DPC #1] were separated." The report indicated "[Client #7] has a BSP (Behavior Support Plan) in place to address verbal and physical aggression. [Client #7] was laid off for 5/16/13 per workshop policy for physical</p>			

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W000159	<p>aggression." No further documentation was available to indicate an investigation was conducted.</p> <p>On 5/1/14 at 11:43 AM during an interview, the Vice President of Residential Services (VPR) indicated it was the facility's policy to investigate client to client abuse. The VPR indicated those incidents of alleged client to client abuse should have been investigated. The VPR indicated incidents which happen at the day program are investigated by the day program. The VPR indicated she knew the facility should have ensured a thorough investigation was completed.</p> <p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>Based on observation, interview, and record review, the facility QIDP (Qualified Intellectual Disabilities Professional) failed to ensure monitoring</p>	W000159	<p>Toensure proper and adequate monitoring and documentation of frequency of falls,the following correction actions will be implemented:</p> <p>1.Client#3's Fall Plan will be updated to indicate a tendency of</p>	06/10/2014			

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	<p>and/or documentation of frequency of falls for 1 of 4 sampled clients (#3).</p> <p>Findings include:</p> <p>On 5/1/14 between 11:30 AM and 3:35 PM, group home observations were conducted during record review as Client #3 remained at the group home and did not attend an outside day program service. At 1:10 PM, Client #3 was sitting on a chair at the kitchen table. Client #3 was unattended when he leaned to his left side and fell onto the floor. DSP (Direct Support Professional) #1 went into the kitchen and leaned down and asked Client #3 if he was "okay." Client #3 is nonverbal and did not indicate whether he sustained any injury. DSP #1 verbally prompted Client #3 but he did not get up. Client #3 remained laying on the floor for 7 minutes until he was prompted again to get into his wheelchair. At 2:47 PM, Client #3 was in the living room with DSP #1 watching television while seated in his wheelchair. DSP #1 was standing behind Client #3 while speaking to him and providing tactile stimulation to calm him by rubbing on his shoulders. Client #3 leaned forward and DSP #1 grabbed his gait belt in the back but Client #3 fell onto the carpeted flooring in the living room onto his knees. DSP #1 asked</p>		<p>frequent falls and drops, what the falls looked like, how falls or drops happened, and any injuries sustained in the fall. The plan will also be updated to include an ambulation plan. To ensure that the revised and updated plan will be successfully implemented and followed, all staff located at the location of 2453 South 100 East (Bobtail group home) will be re-trained on Client #3's fall plan. Refer to Appendix F for Record of Training form to be used to document training.</p> <p>2. Qualified Developmental Disability Professional (QDDP) and Residential House Manager (RHM) will implement Fall/Drop record sheets to track type and frequency of falls and drops. Refer to Appendix G for fall/drop sheet to be implemented. The use of this sheet will be included in Client #3's fall plan.</p> <p>3. Qualified Developmental Disability Professional (QDDP) will seek Human Rights' Committee (HRC) approval for the use of a small gym or similar type mat to be placed at the edge of any chair in which Client #3 is sitting in to protect Client #3 in the event of falls or drops. The approved use of this type of mat will be included in Client #3's fall plan.</p>				

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	<p>Client #3 whether he was "okay". Client #3 began to crawl down the carpeted hallway.</p> <p>On 5/5/14 between 10:27 AM and 2:45 PM, group home observations were conducted during record review. At 11:43 AM, Client #3 did not attend outside day program services on that day, he ate lunch in the kitchen with the assistance of DSP (Direct Support Professional) #2. Client #3 walked over to the kitchen counter area when he was done eating his lunch to assist with clean up. Client #3 walked with an unsteady gait and was wearing a gait belt. DSP #2 assisted Client #3 by holding his gait belt in the back to assist with balance as needed. Client #3 stood at the kitchen counter independently by holding onto the counter. Client #3 lost his balance and fell to the floor and onto his left hip area. DSP #2 had grabbed Client #3's gait belt as he was falling but was unable to prevent the fall. The House Manager (HM) assisted DSP #2 in assisting Client #3 back to a standing position. DSP #2 stated Client #3's gait belt "always slips" when it is grabbed and becomes "loose." The HM and DSP #2 assisted Client #3 into his wheelchair. During an interview at 12:07 PM, the HM stated "yes" it was common for Client #3 to fall. The HM stated Client #3 "flops down all the</p>			

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	<p>time." The HM stated "he has the gait belt, we just use it to lessen the falls."</p> <p>On 5/1/14 at 12:06 PM, the facility's A/I (accident/incident) reports from 1/01/14 to 5/1/14 and BDDS (Bureau of Developmental Disabilities Services) reports from 5/1/13 to 5/1/14 were reviewed. A BDDS report dated 9/23/13 indicated "staff were assisting [Client #3] getting out of the shower when he slipped and fell. Staff examined him and no injury was noted. The next morning, his hand appeared to be swollen. [Client #3] was taken to the doctor to be evaluated. The doctor stated no broken bones or sprains but prescribed an anti-inflammatory." The report indicated "at this time, the swelling has gone down and [Client #3] doesn't exhibit any pain or discomfort."</p> <p>An A/I(accident/incident) report dated 2/15/14 indicated "[Client #3] was being changed, walked across bathroom, was falling. Staff caught him enough to not hit his head but he landed on right arm. Nurse was notified along with the house manager."</p> <p>On 5/5/14 at 11:10 AM, record review indicated Client #3's diagnoses included, but were not limited to, cerebral palsy, autism, seizure disorder, and profound</p>						

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	<p>intellectual disabilities. Record review indicated Client #3's ISP (Individual Support Plan) dated 1/30/13 and revised on 3/4/13 indicated Client #3 had a "Falling Management Plan" dated 3/4/13. Client #3's fall plan indicated Client #3 "experiences muscle spasms due to CP (cerebral palsy). His muscles are very stiff and rigid." The fall plan indicated "[Client #3] walks with stiff, rigid movements. [Client #3] is high risk of falls due to his awkward gait. [Client #3] wears a gait belt for mobility assistance; he has a wheelchair for use as needed, and a helmet for safety purposes." The plan indicated "[Client #3] falls into walls, trips over his feet, and falls into counters." The plan indicated "all falls will be reported to QDDP (Qualified Developmental Disabilities Professional) and residential nursing." Client #3's fall plan indicated the following:</p> <p>** ...remind [Client #3] to wear stable shoes.</p> <p>*make [Client #3] aware, when in the community, of obstacles, rugs, uneven pavement, light changes, and other items that could potentially be a hazard for him. Staff may need to be within an arms' length to offer assistance.</p> <p>* ...will make sure [Client #3] is wearing his helmet and gait belt when ambulating.</p>						

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	<p>* ...will encourage [Client #3] to not bend over so that his head is lower than his heart as this throws off his balance easily.</p> <p>* ...will arrange [Client #3]'s environment to minimize the risk of injury such as throw rugs, furniture against wall, clutter out of hallways, steps and hallways are adequately lit, uses handrails when maneuvering stairs and grab bars are used in bathroom showers and baths.</p> <p>* ...will contact the QDDP and Residential Nurse if a fall occurs.</p> <p>* ...will assess [Client #3] for injury and care for the injury as taught in First Aid.</p> <p>* If the fall is severe in injury, 911 will be called immediately and then the Residential Nurse and the QDDP.</p> <p>* ...will document in daily notes and on an internal accident injury form if a fall occurs...</p> <p>* ...If there is an injury with the fall the QDDP will complete a BDDS (Bureau of Developmental Disabilities Services) report within 24 hours of the fall."</p> <p>Client #3's ISP indicated a BSP (Behavior Support Plan) dated 1/30/13 which indicated targeted behaviors of self-injurious behavior, physical aggression, and property destruction. Client #3's BSP indicated "gait belt" as a "replacement behaviors and redirection"</p>						

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	<p>technique. The BSP indicated "[Client #3] falls and drops to the ground. [Client #3] wears a gait belt to prevent injuries from falling and assist with improving his gait. [Client #3] sometimes falls out of frustration and other times as a way to avoid a task or a situation. Staff will give [Client #3] time to regroup and the (sic) state the task again." The technique indicated "[Client #3] will have assistance to stand and move to a safer or softer area. Staff will give him room to stand on his own." Client #3's BSP did not indicate to staff to document the frequency of falls and how to distinguish the difference between intentional falls and unintentional falls.</p> <p>On 5/5/14 at 2:27 PM during an interview, the House Manager (HM) indicated there was no documentation for Client #3's falls which occurred during group home observations. The HM indicated there was no fall log or documentation to indicate the frequency of Client #3's falls. HM indicated Client #3's BSP does not indicate how to track intentional falls.</p> <p>9-3-3(a)</p>			

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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.</p> <p>Based on observation, record review, and interview for 1 of 4 sampled clients (#1), the facility failed to include speech recommendations in the client's ISP (Individual Support Plan).</p> <p>Findings include:</p> <p>On 4/30/14 between 4:35 PM and 6:08 PM and on 5/1/14 between 6:15 AM and 7:45 AM, group home observations were conducted. During group home observations, Client #1 spoke in one to three word phrases and did not utilize a picture communication system to augment his speech.</p> <p>On 5/1/14 at 1:40 PM, record review indicated Client #1's diagnoses included, but were not limited to, intellectual disability, Down's Syndrome, and</p>	W000227	<p>To ensure that an individual support plan is being followed as written to best benefit the client, the following correction actions will be implemented:</p> <p>1. Client #1's Individual Support Plan (ISP) and Communication Plan will be updated to include the use of picture communication systems to help augment speech.</p> <p>2. To ensure that the revised and updated plan will be successfully implemented and followed, all staff located at the location of 2453 South 100 East (Bobtail group home) will be re-trained on Client #1's Communication and Individual Support plans. Refer to Appendix H for Record of Training form to be used to document training.</p>	06/10/2014

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	<p>dementia. Record review indicated Client #1 had a speech evaluation dated 3/23/10 which indicated Client #1 had the ability to use one word phrases and recommended use of pictures to augment his speech ability.</p> <p>The record review indicated Client #1's ISP (Individual Support Plan) dated 10/7/13 included a "Communication Plan" dated 10/7/13 which indicated "[Client #1] has a difficult time with properly annunciating his words, which causes other individuals to not be able to understand him. [Client #1] also tends to mumble and talk softly which makes it difficult to understand him. Due to [Client #1]'s limited communication, he tends to speak in mostly one and two word sentences. Furthermore, his speech is very difficult to understand for those that are less familiar with him." The communication plan indicated the following "Implementation:"</p> <p>"* ...ensure that [Client #1] communicates his needs with verbal prompts. * ...ensure [Client #1]'s needs are met. * ...decrease environmental stimuli. * ...use short repetitive directions. * ...ask simple yes or no questions. * ...validate [Client #1]'s message by repeating aloud.</p>			

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	<p>* ...ask [Client #1] to repeat what was said by the other person to clarify understanding.</p> <p>* ...allow an appropriate amount of time for [Client #1] to process the request."</p> <p>Client #1's ISP indicated a communication goal to increase communication skills. The goal indicated Client #1 "has very limited verbal skills. It is often difficult to determine what [Client #1] is saying. [Client #1] uses gestures and some verbal cues to indicate what he is trying to say." The goal indicated Client #1 "has been diagnosed with early stage dementia and would have a difficult time learning new communication skills." Client #1's communication goal indicated Client #1 would indicate 'yes' or 'no' by "nodding or shaking my head with 3 or less verbal prompts... ."</p> <p>On 5/5/14 at 2:27 PM during an interview, the House Manager (HM) indicated she doesn't remember Client #1 ever using a picture communication system. The HM indicated the speech evaluation recommendations may not have been ever included in Client #1's ISP. The HM indicated Client #1 might benefit from using pictures to communicate.</p>				

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W000240	<p>9-3-4(a)</p> <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 observation, interview, and record review, the facility failed to develop and ensure monitoring and/or documentation of frequency of falls for 1 of 4 sampled clients (#3).</p> <p>Findings include:</p> <p>On 5/1/14 between 11:30 AM and 3:35 PM, group home observations were conducted during record review as Client #3 remained at the group home and did not attend an outside day program service. At 1:10 PM, Client #3 was sitting on a chair at the kitchen table. Client #3 was unattended when he leaned to his left side and fell onto the floor. DSP (Direct Support Professional) #1 went into the kitchen and leaned down and asked Client #3 if he was "okay."</p>	W000240	<p>Toensure proper and adequate monitoring and documentation of frequency of falls,the following correction actions will be implemented:</p> <p>1.Client#3's Fall Plan will be updated to indicate a tendency of frequent falls anddrops, what the falls looked like, how falls or drops happened, and anyinjuries sustained in the fall. The plan will also be updated to include anambulation plan. To ensure that the revised and updated plan will besuccessfully implemented and followed, all staff located at the location of2453 South 100 East (Bobtail group home) will be re-trained on Client #3's fallplan. <i>Refer to Appendix F for Record ofTraining form to be used to document training.</i></p> <p>2.QualifiedDevelopmental Disability Professional (QDDP) and Residential House</p>	06/10/2014	

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	<p>Client #3 is nonverbal and did not indicate whether he sustained any injury. DSP #1 verbally prompted Client #3 but he did not get up. Client #3 remained laying on the floor for 7 minutes until he was prompted again to get into his wheelchair. At 2:47 PM, Client #3 was in the living room with DSP #1 watching television while seated in his wheelchair. DSP #1 was standing behind Client #3 while speaking to him and providing tactile stimulation to calm him by rubbing on his shoulders. Client #3 leaned forward and DSP #1 grabbed his gait belt in the back but Client #3 fell onto the carpeted flooring in the living room onto his knees. DSP #1 asked Client #3 whether he was "okay". Client #3 began to crawl down the carpeted hallway.</p> <p>On 5/5/14 between 10:27 AM and 2:45 PM, group home observations were conducted during record review. At 11:43 AM, Client #3 did not attend outside day program services on that day, he ate lunch in the kitchen with the assistance of DSP (Direct Support Professional) #2. Client #3 walked over to the kitchen counter area when he was done eating his lunch to assist with clean up. Client #3 walked with an unsteady gait and was wearing a gait belt. DSP #2 assisted Client #3 by holding his gait belt</p>		<p>Manager(RHM) will implement Fall/Drop record sheets to track type and frequency offalls and drops. Refer to Appendix G forfall/drop sheet to be implemented. The use of this sheet will be includedin Client #3's fall plan.</p>				

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	<p>in the back to assist with balance as needed. Client #3 stood at the kitchen counter independently by holding onto the counter. Client #3 lost his balance and fell to the floor and onto his left hip area. DSP #2 had grabbed Client #3's gait belt as he was falling but was unable to prevent the fall. The House Manager (HM) assisted DSP #2 in assisting Client #3 back to a standing position. DSP #2 stated Client #3's gait belt "always slips" when it is grabbed and becomes "loose." The HM and DSP #2 assisted Client #3 into his wheelchair. During an interview at 12:07 PM, the HM stated "yes" it was common for Client #3 to fall. The HM stated Client #3 "flops down all the time." The HM stated "he has the gait belt, we just use it to lessen the falls."</p> <p>On 5/1/14 at 12:06 PM, the facility's A/I (accident/incident) reports from 1/01/14 to 5/1/14 and BDDS (Bureau of Developmental Disabilities Services) reports from 5/1/13 to 5/1/14 were reviewed. A BDDS report dated 9/23/13 indicated "staff were assisting [Client #3] getting out of the shower when he slipped and fell. Staff examined him and no injury was noted. The next morning, his hand appeared to be swollen. [Client #3] was taken to the doctor to be evaluated. The doctor stated no broken bones or sprains but prescribed an</p>				

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	<p>anti-inflammatory." The report indicated "at this time, the swelling has gone down and [Client #3] doesn't exhibit any pain or discomfort."</p> <p>An A/I(accident/incident) report dated 2/15/14 indicated "[Client #3] was being changed, walked across bathroom, was falling. Staff caught him enough to not hit his head but he landed on right arm. Nurse was notified along with the house manager."</p> <p>On 5/5/14 at 11:10 AM, record review indicated Client #3's diagnoses included, but were not limited to, cerebral palsy, autism, seizure disorder, and profound intellectual disabilities. Record review indicated Client #3's ISP (Individual Support Plan) dated 1/30/13 and revised on 3/4/13 indicated Client #3 had a "Falling Management Plan" dated 3/4/13. Client #3's fall plan indicated Client #3 "experiences muscle spasms due to CP (cerebral palsy). His muscles are very stiff and rigid." The fall plan indicated "[Client #3] walks with stiff, rigid movements. [Client #3] is high risk of falls due to his awkward gait. [Client #3] wears a gait belt for mobility assistance; he has a wheelchair for use as needed, and a helmet for safety purposes." The plan indicated "[Client #3] falls into walls, trips over his feet, and falls into</p>			

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	<p>counters." The plan indicated "all falls will be reported to QDDP (Qualified Developmental Disabilities Professional) and residential nursing." Client #3's fall plan indicated the following:</p> <p>"* ...remind [Client #3] to wear stable shoes.</p> <p>* ...make [Client #3] aware, when in the community, of obstacles, rugs, uneven pavement, light changes, and other items that could potentially be a hazard for him. Staff may need to be within an arms' length to offer assistance.</p> <p>* ...will make sure [Client #3] is wearing his helmet and gait belt when ambulating.</p> <p>* ...will encourage [Client #3] to not bend over so that his head is lower than his heart as this throws off his balance easily.</p> <p>* ...will arrange [Client #3]'s environment to minimize the risk of injury such as throw rugs, furniture against wall, clutter out of hallways, steps and hallways are adequately lit, uses handrails when maneuvering stairs and grab bars are used in bathroom showers and baths.</p> <p>* ...will contact the QDDP and Residential Nurse if a fall occurs.</p> <p>* ...will assess [Client #3] for injury and care for the injury as taught in First Aid.</p> <p>* If the fall is severe in injury, 911 will</p>			

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	<p>be called immediately and then the Residential Nurse and the QDDP.</p> <p>* ...will document in daily notes and on an internal accident injury form if a fall occurs...</p> <p>* ...If there is an injury with the fall the QDDP will complete a BDDS (Bureau of Developmental Disabilities Services) report within 24 hours of the fall."</p> <p>Client #3's ISP indicated a BSP (Behavior Support Plan) dated 1/30/13 which indicated targeted behaviors of self-injurious behavior, physical aggression, and property destruction. Client #3's BSP indicated "gait belt" as an "replacement behaviors and redirection" technique. The BSP indicated "[Client #3] falls and drops to the ground. [Client #3] wears a gait belt to prevent injuries from falling and assist with improving his gait. [Client #3] sometimes falls out of frustration and other times as a way to avoid a task or a situation. Staff will give [Client #3] time to regroup and the (sic) state the task again." The technique indicated "[Client #3] will have assistance to stand and move to a safer or softer area. Staff will give him room to stand on his own."</p> <p>Client #3's BSP did not indicate to staff how to distinguish the difference between intentional falls and unintentional falls.</p>			
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W000262	<p>On 5/5/14 at 2:27 PM during an interview, the House Manager (HM) indicated there was no documentation for Client #3's falls which occurred during group home observations. The HM indicated there was no fall log or documentation to indicate the frequency of Client #3's falls. HM indicated Client #3's BSP does not indicate how to track intentional falls.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.</p> <p>Based on record review and interview, the facility failed to ensure the Human Rights Committee reviewed and approved the client's use of psychotropic medication (anti-anxiety, Valium) for daily use for 1 of 4 sampled clients (#3).</p>	W000262	<p>To ensure that all prescribed medications are approved for use, the following correction actions will be implemented:</p> <p>1. Client #3's prescribed scheduled Valium 2mg TID (three times daily) will be submitted to the Human Rights Committee (HRC) to seek immediate approval.</p>	06/10/2014			

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	<p>Findings include:</p> <p>On 5/5/14 at 11:10 AM, record review indicated Client #3's diagnoses included, but were not limited to, cerebral palsy, autism, seizure disorder, and profound intellectual disabilities. Client #3's MAR (medication administration record) dated 4/30/14 indicated Client #3 was prescribed the following medication for behavior: Diazepam 2mg (anti-anxiety, Valium) (milligrams) TID (three times daily), Paroxetine 30mg (antidepressant, Paxil) QD (once daily), Ziprasidone 60mg (antipsychotic, Geodon) BID (twice daily), Abilify 20mg (antipsychotic) QD.</p> <p>Record review indicated a "Human Rights Committee (HRC) Review" dated 4/29/14 which indicated the committee approved the following medications: Paroxetine 30mg, Abilify 20mg, Geodon 60mg, and Valium 2mg (given as needed for "Dental Visits"). Client #3's prescribed scheduled Valium 2mg TID (three times daily) was not on the list of HRC approved medications.</p> <p>On 5/5/14 at 2:27 PM during an interview, the House Manager (HM) stated "it must have been a mistake" that Client #3's prescribed scheduled Valium 2mg given TID was not on the HRC list</p>		<p>2. Upon approval for use from HRC, the Medication Administration Record (MAR) will be updated to include prescribed medication.</p> <p>3. To ensure that the prescribed medicine is distributed to Client #3 accurately and as prescribed, all staff located at the location of 2453 South 100 East (Bobtail group home) will be re-trained on medication administration for Client #3's. Refer to Appendix I for Record of Training form to be used to document training.</p>		

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W000331	<p>of approved psychotropic medications for Client #3. The House Manager indicated Client #3's prescribed scheduled Valium should have been approved by the HRC.</p> <p>9-3-4(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, record review, and interview, the facility nursing staff failed to update a client's fall risk plan to prevent recurrent falls for 1 of 4 sampled clients (#3).</p> <p>Based on record review and interview, the facility nursing staff failed to develop and implement a Congestive Heart Failure (CHF) high risk plan which included specific signs and symptoms of CHF to monitor for 1 of 4 sampled clients (#1).</p> <p>Based on record review and interview, the facility nursing staff failed to clarify a physician's order for a PRN (given as needed) medication prescribed for seizures for 1 of 4 sampled clients (#2).</p> <p>Findings include:</p>			W000331	<p>Toensure that nursing services are provided in accordance with client needs, thefollowing correction actions will be implemented:</p> <p>1.Client#3's Fall Plan will be updated to indicate a tendency of frequent falls anddrops, what the falls looked like, how falls or drops happened, and anyinjuries sustained in the fall. The plan will also be updated to include anambulation plan. To ensure that the revised and updated plan will besuccessfully implemented and followed, all staff located at the location of2453 South 100 East (Bobtail group home) will be re-trained on Client #3's fallplan. <i>Refer to Appendix F for Record ofTraining form to be used to document training.</i></p> <p>2.ACongestive Heart Failure Plain will be implemented for Client #1. The plan willbe drafted to include specific signs and symptom of congestive heart</p>		06/10/2014

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	<p>1) On 5/1/14 between 11:30 AM and 3:35 PM, group home observations were conducted during record review as Client #3 remained at the group home and did not attend an outside day program service. At 1:10 PM, Client #3 was sitting on a chair at the kitchen table. Client #3 was unattended when he leaned to his left side and fell onto the floor. DSP (Direct Support Professional) #1 went into the kitchen and leaned down and asked Client #3 if he was "okay." Client #3 is nonverbal and did not indicate whether he sustained any injury. DSP #1 verbally prompted Client #3 but he did not get up. Client #3 remained laying on the floor for 7 minutes until he was prompted again to get into his wheelchair. At 2:47 PM, Client #3 was in the living room with DSP #1 watching television while seated in his wheelchair. DSP #1 was standing behind Client #3 while speaking to him and providing tactile stimulation to calm him by rubbing on his shoulders. Client #3 leaned forward and DSP #1 grabbed his gait belt in the back but Client #3 fell onto the carpeted flooring in the living room onto his knees. DSP #1 asked Client #3 whether he was "okay". Client #3 began to crawl down the carpeted hallway.</p> <p>On 5/5/14 between 10:27 AM and 2:45</p>		<p>failure. To ensure that the revised and updated plan will be successfully implemented and followed, all staff located at the location of 2453 South 100 East (Bobtail group home) will be trained on Client #1's risk plan. Refer to Appendix J for Record of Training form to be used to document training.</p> <p>3. Nursing staff will contact physician for Client #2 to clarify physician's for PRN medication for seizures. The seizure plan for Client # 2 will be updated to differentiate when to administer Clonazepam 1mg and indicate its uses. To ensure that the prescribed medicine is distributed to Client #3 accurately and as prescribed, all staff located at the location of 2453 South 100 East (Bobtail group home) will be re-trained on medication administration for Client #2's. Refer to Appendix K for Record of Training form to be used to document training.</p>				

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	<p>PM, group home observations were conducted during record review. At 11:43 AM, Client #3 did not attend outside day program services on that day, he ate lunch in the kitchen with the assistance of DSP (Direct Support Professional) #2. Client #3 walked over to the kitchen counter area when he was done eating his lunch to assist with clean up. Client #3 walked with an unsteady gait and was wearing a gait belt. DSP #2 assisted Client #3 by holding his gait belt in the back to assist with balance as needed. Client #3 stood at the kitchen counter independently by holding onto the counter. Client #3 lost his balance and fell to the floor and onto his left hip area. DSP #2 had grabbed Client #3's gait belt as he was falling but was unable to prevent the fall. The House Manager (HM) assisted DSP #2 in assisting Client #3 back to a standing position. DSP #2 stated Client #3's gait belt "always slips" when it is grabbed and becomes "loose." The HM and DSP #2 assisted Client #3 into his wheelchair. During an interview at 12:07 PM, the HM stated "yes" it was common for Client #3 to fall. The HM stated Client #3 "flops down all the time." The HM stated "he has the gait belt, we just use it to lessen the falls."</p> <p>On 5/1/14 at 12:06 PM, the facility's A/I (accident/incident) reports from 1/01/14</p>						

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	<p>to 5/1/14 and BDDS (Bureau of Developmental Disabilities Services) reports from 5/1/13 to 5/1/14 were reviewed. A BDDS report dated 9/23/13 which indicated "staff were assisting [Client #3] getting out of the shower when he slipped and fell. Staff examined him and no injury was noted. The next morning, his hand appeared to be swollen. [Client #3] was taken to the doctor to be evaluated. The doctor stated no broken bones or sprains but prescribed an anti-inflammatory." The report indicated "at this time, the swelling has gone down and [Client #3] doesn't exhibit any pain or discomfort."</p> <p>An A/I(accident/incident) report dated 2/15/14 indicated "[Client #3] was being changed, walked across bathroom, was falling. Staff caught him enough to not hit his head but he landed on right arm. Nurse was notified along with the house manager."</p> <p>On 5/5/14 at 11:10 AM, record review indicated Client #3's diagnoses included, but were not limited to, cerebral palsy, autism, seizure disorder, and profound intellectual disabilities. Record review indicated Client #3's ISP (Individual Support Plan) dated 1/30/13 and revised on 3/4/13 indicated Client #3 had a "Falling Management Plan" dated 3/4/13.</p>						

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	<p>Client #3's fall plan indicated Client #3 "experiences muscle spasms due to CP (cerebral palsy). His muscles are very stiff and rigid." The fall plan indicated "[Client #3] walks with stiff, rigid movements. [Client #3] is high risk of falls due to his awkward gait. [Client #3] wears a gait belt for mobility assistance; he has a wheelchair for use as needed, and a helmet for safety purposes." The plan indicated "[Client #3] falls into walls, trips over his feet, and falls into counters." The plan indicated "all falls will be reported to QDDP (Qualified Developmental Disabilities Professional) and residential nursing." Client #3's fall plan indicated the following:</p> <p>"* ...remind [Client #3] to wear stable shoes.</p> <p>* ...make [Client #3] aware, when in the community, of obstacles, rugs, uneven pavement, light changes, and other items that could potentially be a hazard for him. Staff may need to be within an arms' length to offer assistance.</p> <p>* ...will make sure [Client #3] is wearing his helmet and gait belt when ambulating.</p> <p>* ...will encourage [Client #3] to not bend over so that his head is lower than his heart as this throws off his balance easily.</p> <p>* ...will arrange [Client #3]'s</p>						

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	<p>environment to minimize the risk of injury such as throw rugs, furniture against wall, clutter out of hallways, steps and hallways are adequately lit, uses handrails when maneuvering stairs and grab bars are used in bathroom showers and baths.</p> <ul style="list-style-type: none"> * ...will contact the QDDP and Residential Nurse if a fall occurs. * ...will assess [Client #3] for injury and care for the injury as taught in First Aid. * If the fall is severe in injury, 911 will be called immediately and then the Residential Nurse and the QDDP. * ...will document in daily notes and on an internal accident injury form if a fall occurs... * ...If there is an injury with the fall the QDDP will complete a BDDS (Bureau of Developmental Disabilities Services) report within 24 hours of the fall." <p>On 5/5/14 at 2:27 PM during an interview, the House Manager (HM) indicated there was no documentation for Client #3's falls which occurred during group home observations. The HM indicated there was no fall log or documentation to indicate the frequency of Client #3's falls. The facility nurse indicated Client #3's fall plan had not been revised and/or updated to prevent recurrence of falls.</p>			

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	<p>2) On 5/1/14 at 1:40 PM, record review indicated Client #1's diagnoses included, but were not limited to, intellectual disabilities, Down's syndrome, CHF (congestive heart failure), dementia, and sleep apnea.</p> <p>Review of Client #1's MAR (medication administration record) dated 4/30/14 indicated staff were to "check blood pressure every Saturday", "weigh monthly, every Saturday of each month", "oxygen 3 liters via nasal cannula (tubing) HS (at night)", "chest pain/heart burns document on nurses notes on back. Call Nurse or supervisor/911 (emergency line)."</p> <p>Record review indicated Client #1's ISP (Individual Support Plan) dated 10/7/13 indicated a "CHF (congestive heart failure) Plan" dated 10/7/13 which indicated "[Client #1] has a diagnosis of Congestive Heart Failure (CHF). Heart Failure (HF), often called congestive heart failure (CHF) or congestive cardiac failure (CCF), occurs when the heart is unable to provide sufficient pump action to maintain blood flow to meet the needs of the body. Heart failure can cause a number of symptoms including shortness of breath, leg swelling, and exercise intolerance." The plan indicated indicated the following</p>				

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	<p>"Implementation:"</p> <p>"* ... will administer medications as prescribed by the physician. * ...will document medication administration on the MAR (medication administration record). * ...will observe [Client #1] for any signs or symptoms of CHF. * ...will call 911 if [Client #1] is experiencing life threatening symptoms. * ...will then notify the QDDP (Qualified Developmental Disabilities Professional), Residential Nurse and the Director of Residential Services. * [Client #1] will see his PCP (primary care physician) and cardiologist as needed for issues pertaining to CHF."</p> <p>The CHF care plan did not include a specific list of signs and symptoms of CHF. The CHF care plan did not include Client #1's use of oxygen. The CHF plan did not indicate which symptoms were life threatening and when to call 911.</p> <p>On 5/5/14 at 2:27 PM during an interview, the facility Nurse reviewed Client #1's CHF care plan and indicated it should be more specific. The Nurse indicated a complete list of signs of symptoms should be in the CHF care plan and which signs and symptoms were life threatening.</p>				

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	<p>3) On 5/1/14 at 2:40 PM, record review indicated Client #2's diagnoses included, but were not limited to, intellectual disabilities and seizure disorder. Record review indicated Client #2's MAR (medication administration record) dated 4/30/14 indicated Client #2 was prescribed two PRN (given as needed) medications for seizures which included Diazepam (anti-convulsant) 10 MG (milligrams) rectally given "as needed for seizures" and Clonazepam (Klonopin) 1 MG "twice a day as needed for seizures."</p> <p>Client #2's ISP (Individual Support Plan) dated 12/3/13 indicated a "Seizure Management Plan" dated 12/3/13 which indicated "[Client #2] has a VNS (vagal nerve stimulator) (used to attempt to end a seizure)." The plan also indicated "he also has PRN rectal Diastat for seizures lasting longer than 5 minutes." Client #2's "Seizure Management Plan" did not specify when to administer the Clonazepam 1 MG.</p> <p>On 5/5/14 at 2:27 PM during an interview, the facility Nurse indicated Client #2's seizure care plan should be more specific. The Nurse indicated Client #2's seizure plan should have indicated the use for the Clonazepam 1 MG and should have specified when staff</p>			

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NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2453 S 100 E PERU, IN 46970
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(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
W000488	<p>were to administer it.</p> <p>9-3-6(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation and interview for 8 of 8 clients (#1, #2, #3, #4, #5, #6, #7, #8), the facility failed to encourage clients to function with as much independence to the extent possible in regards to family style dining.</p> <p>Findings include:</p> <p>On 4/30/14 between 4:35 PM and 6:08 PM, group home observations were conducted. At 4:35 PM, Clients #2, #3, #4, #5, #6, #7, and #8 were eating dinner. The clients were eating a beef noodle stew in a bowl with corn bread. There were no family style serving dishes on the tables. There were no condiments (no butter, salt, or pepper) on the table. At 4:40 PM, DSP (Direct Support</p>	W000488	<p>To ensure that clients are encouraged to function with as much independence as possible, the following correction actions will be implemented:</p> <p>To ensure that the clients are encouraged to practice independence during meal times, all staff located at the location of 2453 South 100 East (Bobtail group home) will be re-trained on family style dining. Refer to Appendix L for Record of Training form to be used to document training</p>	06/10/2014

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	<p>Professional) #3 asked Client #4 what she "wanted more of?" Client #4 pointed to her stew bowl and corn bread dish. DSP #3 went to the kitchen and got a second helping of stew and corn bread for Client #4 without her assistance. DSP #4 swept the floor around the small table in the kitchen where Client #3 and Client #8 ate their dinner without client assistance. Client #7 independently put his bowl in the sink after he was finished eating. DSP #3 took Client #5's bowl from the table to the kitchen sink without his assistance. DSP #3 indicated Client #8 was blind and doesn't speak while she wiped his hands with wipes without his assistance. DSP #4 wiped off the small table in the kitchen with a washcloth with no client assistance.</p> <p>On 5/1/14 between 6:15 AM and 7:45 AM, group home observations were conducted. At 6:15 AM, breakfast was being served. DSP (Direct Support Professional) #5 poured Client #6's coffee, put her substitute sweetener in it and stirred it for her. DSP #5 poured Client #4's coffee, added sweetener, and stirred it for her. DSP #5 brought a plate of english muffins and asked Client #7 if she could pour his juice for him and he indicated yes. DSP #5 poured Client #6's juice. DSP #5 poured and prepared Client #7's coffee. Client #4 put butter</p>						

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	<p>on her english muffin. Client #2 slept at the table. Client #7 put peanut butter on his english muffin independently. DSP #5 asked Client #1 if he wanted coffee and she poured it for him. DSP #5 poured Client #7's cereal into a bowl for him without his assistance. Client #8 walked into the kitchen independently. DSP #7 assisted Client #8 to his chair at the small table in the kitchen. DSP #5 poured Client #7's cereal for him. DSP #5 asked Client #4 if she would like to pour her own cereal and she indicated she did. Client #4 poured her cereal. DSP #5 poured Client #7 and Client #4's milk into their bowls. At 6:49 AM, DSP #5 poured cereal into a bowl, poured milk into it and set it in front of Client #8. DSP #5 brought an english muffin on a plate and put peanut butter on it. DSP #5 prepared a small plate of fruit and took the two plates to Client #8. DSP #6 poured cereal for Client #8. DSP #1 prompted Client #1 using verbal prompts to pour his juice. Client #1 was sleeping at the table and DSP #1 poured his juice for him. DSP #5 poured milk into a cup for Client #3. Client #6 put her fruit on a plate independently. At 6:56 AM, DSP #3 indicated she would prepare waffles for Client #3 since he did not eat his cereal.</p> <p>On 5/5/14 at 2:27 PM during an</p>			

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	interview, the House Manager (HM) indicated staff should be encouraging the clients (#1, #2, #3, #4, #5, #6, #7, and #8) to be as independent as possible during dining tasks. The HM indicated clients should have been given the opportunity to serve themselves at meal times. 9-3-8(a)						