STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G535	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONA VISTA PROGRAMS INC	1901 W GOLDEN HILLS DR PERU, IN 46970

(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
W 0000 Bldg. 00	This visit was for a fundamental annual recertification and state licensure survey. Dates of survey: 1/26, 1/27, 1/28, 1/29, 2/1, 2/2, 2/3, 2/4, and 2/5/16. Provider Number: 15G535 Facility Number: 001049 AIM Number: 100245300 These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 2/15/16.	W 0000		
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review, and interview, for 4 of 4 sample clients (clients #1, #2, #3, and #4) and 4 additional clients (clients #5, #6, #7, and #8), the governing body failed to exercise operating direction over the facility to ensure maintenance and repairs were completed at the group home for clients #1, #2, #3, #4, #5, #6, #7, and #8.	W 0104	**W104** **Finding(s):** **1.“*Basedon observation, record review, and interview, for 4 of 4 sample clients (#1, #2,#3, and #4) and 4 additional clients (#5, #6, #7, and #8 the governing bodyfailed to exercise operating direction over the facility to ensure maintenanceand repairs were completed at the group home***	03/06/2016

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.

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	Findings include: On 1/27/16 from 5:55am until 8:45am and on 1/28/16 at 9:40am, observations and interviews were conducted at clients #1, #2, #3, #4, #5, #6, #7, and #8's group home. On 1/27/16 from 5:55am until 8:45am, clients #1, #2, #3, #4, #5, #6, #7, and #8 were observed at the group home. On 1/28/16 at 9:40am, the RM (Residential Manager) indicated the group home was in need of the following repairs: -The RM indicated 3 of 3 bathrooms were in need of maintenance and repairs. -The green colored bathroom tub was discolored and worn. The green colored bathroom tile around the tub had one foot long by one foot wide (1' x 1') tiles with five feet (5') of tiles cracked and broken. The green colored bathroom had 2 of 3 shower walls discolored and worn. The green colored bathroom shower had a rusty shower head. -The bathroom across from the medication room had the paint around the shower stall peeling. The shower had three (3) rusted areas which were each two feet (2') tall in the seams of the shower walls. The shower head and controls were rusted. -The back bathroom had a rusted shower curtain rod.		***for clients #1, #2, #3, #4, #5,#6, #7, and #8. "*** **CorrectiveAction(s):** **Toensure the facilities governing body operates direction over the group home toensure that maintenance and repairs are completed:** 1.TheResidential House Manager does a safety check and report every Monday of thegroup home. Any maintenance and repairs are submitted in that report. TheResidential House Manager files an electronic maintenance request for thosemaintenance repairs. The Residential Director of Quality Assurance and SocialServices reviews the safety reports on a weekly basis for administrativeoversight and monitors these. The Residential Director of Quality Assurance andSocial Services does a quarterly Periodic Service Review in the home where thehome is thoroughly audited and inspected for additional administrative oversight.The Residential House Manager will be retrained on the weekly safety checks andreports. Record of Training forms will be completed following staff trainingsand will be submitted to the Residential Director for administrative oversight. -	

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	-The RM indicated clients #6 and #8's wooden bedroom door had a hole into the wood. The RM stated client #2 had "punched a hole into the door" during her behavior. The RM indicated clients #2 and #5's shared closet did not have a closure to separate the closet from the shared bedroom. On 2/5/16 at 1:35pm, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional) and the Residential Director of Operations (RDO). The QIDP and RDO both indicated clients #1, #2, #3, #4, #5, #6, #7, and #8's group home was in the process of being repaired. The RDO indicated no further information was available for review. 9-3-1(a)			
W 0125 Bldg. 00	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on observation, record review, and	W 0125	**W125**	03/06/2016

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	interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 4 additional clients (clients #5, #6, #7, and #8), the facility failed to ensure clients #1, #2, #3, #4, #5, #6, #7, and #8 were allowed unimpeded access to their locked snacks. Based on observation, record review, and interview, for 1 of 4 sampled clients (client #1), the facility failed to ensure client #1 had a legally sanctioned representative to assist his with medical and financial needs per his assessments. Findings include: 1. On 1/27/16 from 5:55am until 8:45am, clients #1, #2, #3, #4, #5, #6, #7, and #8 were observed at the group home and the snack closet was kept locked. During the observation period facility staff used a key to access the locked closet to retrieve snack items, pudding cups, fruit cups, cereal boxes, fruit, bags of potato chips, pancake syrup, and dried items used for cooking. At 7:30am, clients #1, #2, #5, and #8 indicated they did not have a key to the locked snack closet. Client #8 stated "snacks closet is locked because of diabetic (clients) and food clients can't have" was inside the closet. Client #5 indicated she wanted to get her own items from the closet. At		**Finding(s):** **1.*"Basedon observation, record review, and interview, for 1 of 4 sampled clients (#1,#2, #3, and #4) and 4 additional sampled clients (#5, #6, #7, and #8), thefacility failed to ensure clients #1, #2, #3, #4, #5, #6, #7, and #8 wereallowed unimpeded access to their locked snacks.*** **CorrectiveAction(s):** **Toensure that clients #1, #2, #3, #4, #5, #6, #7, and #8 has access to theirsnacks:** 1.Allstaff located in the home will be retrained on protection of client rights inregards to not having food restricted. Record of Training will be completedfollowing staff trainings and will be submitted to the Residential Director foradministrative oversight. **Finding(s):** ***1."Thefacility failed to ensure client #1 had a legally sanctioned representative toassist with his medical and financial needs."*** **CorrectiveAction(s):** **Toensure that client #1 receives a legally sanctioned representative to assisthim with his medical and financial needs:**	

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	8:15am, client #1 stated the snack closet was "always locked" and indicated he did not have a key. During the observation period clients #1, #2, #3, #4, #5, #6, #7, and #8 were not taught and encouraged to access the locked snack closet with staff. On 1/27/16 at 10:50am, client #1's record was reviewed. Client #1's 5/14/15 ISP (Individual Support Plan) and record did not indicate an assessment, consent, and/or notification which included information regarding the facility locking the snack closet in the group home. On 1/28/16 at 10:40am, client #2's record was reviewed. Client #2's 5/14/15 ISP (Individual Support Plan) and record did not indicate an assessment, consent, and/or notification which included information regarding the facility locking the snack closet in the group home. On 1/28/16 at 9:35am, client #3's record was reviewed. Client #3's 7/1/15 ISP (Individual Support Plan) and record did not indicate an assessment, consent, and/or notification which included information regarding the facility locking the snack closet in the group home. On 1/27/16 at 11:55am, client #4's record was reviewed. Client #4's 12/10/15 ISP (Individual Support Plan) and record did		1.TheQualified Intellectual Disabilities Professional (QIDP) will actively seek thatclient #1 obtains a legally sanctioned representative to assist him with hismedical and financial needs.	

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	not indicate an assessment, consent, and/or notification which included information regarding the facility locking the snack closet in the group home. An interview on 1/27/16 at 1:15pm, with the Residential Manager (RM) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The RM and QIDP both indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 did not have the identified need for the locked secured snack closet. The RM and QIDP both indicated no consents, assessments, and further information were available for review. On 2/5/16 at 1:35pm, an interview with the Residential Director of Operation (RDO) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The RDO and QIDP indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 did not have the identified need for the locked snack closet at the group home. 2. During observations on 1/26/16 from 3:50pm until 6:05pm and on 1/27/16 from 5:55am until 8:45am, client #1 was observed with the group home staff. During both observation periods client #1 was prompted to use the bathroom, complete tasks in the dining room, and			

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	table to eat. On 1/27/16 at 8:15am, client #1 indicated he did not manage his own money and needed assistance with his medications. Client #1's 5/14/15 ISP and 2015 Risk Assessment indicated client #1 "is emancipated at this time." Client #1's ISP indicated client #1 required staff assistance to initiate and needed assistance to complete daily living skills; needed assistance to complete and follow step by step instructions; "Staff assist [client #1] in managing his finances in the group home...He is dependent on staff to pay for purchases;" client #1 did not recognize dangers in the group home or community; was not independent with his medication administration; and did not recognize abuse, neglect, and/or mistreatment. Client #1's record indicated he needed assistance of staff to help with financial and medical decisions. Client #1's ISP, Risk Assessment, and 9/2015 BSP (Behavior Support Plan) indicated client #1 was not independent with his finances and/or medical care. Client #1's Risk Assessment, ISP, and BSP indicated the following areas were reviewed: personal finances, housing, personal safety, medical, behavioral, and civil rights. The assessments, ISP, and			

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	BSP indicated client #1 required twenty-four hour supervision and assistance to understand and to be able to give informed consent in each area. Client #1's record indicated client #1 did not have a current legally sanctioned representative. Client #1's record indicated he was not able to understand to advocate his rights independently. No additional information was available for review to determine if a guardian had been sought. On 2/5/16 at 1:35pm, an interview with the Residential Director of Operation (RDO) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The RDO and QIDP both indicated client #1's record, Risk Assessment, ISP, and BSP did indicate he needed a legally sanctioned representative to assist him with the "decision making process" for medications and with his finances. The RDO indicated client #1 did not have a legally sanctioned representative at this time. The RDO indicated client #1 had been referred for a guardian and no guardian had been identified at this time. The RDO indicated client #1 did not understand his rights, medications, or money, and needed an advocate to assist to explain his rights.			

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	9-3-2(a)			
W 0140 Bldg. 00	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview, for 1 of 4 sample clients (client #3) who had personal money entrusted to the facility, the facility failed to ensure accurate accounting of client #3's personal funds and failed to follow their policy and procedure for client finances. Findings include: On 1/27/16 at 10:45am, client #3's personal funds were audited with the RM (Residential Manager) at the group home. Client #3's "Cash" on hand ledger indicated $11.18, client #3's personal funds ledger indicated $11.18, and a clear Ziploc baggie dated "10/20/15" with client #3's name and United States currency coins. The RM counted and stated the coins inside the baggie to total "$4.21." The RM stated client #3's "baggie" of coins was "extra money" and was not accounted for in client #3's ledgers and cash on hand statements. When asked if this was a full accounting of client #3's funds, the RM stated "No."	W 0140	**W140** **Finding(s):** ***1."Basedon observation, interview and record review for 1 of 4 sample clients (client#3) who had personal money entrusted to the facility, the facility failed toensure accurate accounting of client #3's personal funds and failed to followtheir policy and procedure for client finances."*** **CorrectiveAction(s):** **Toensure accurate accounting of all clients' funds and to follow all agencypolicy and procedures for client finances.** 1.All staff located in the home will beretrained on agency policy and procedures on client finances to ensure accurateaccounting of all client funds. The Residential House Manager will look overall documented finances in the group home on a weekly basis. The ResidentialDirector of Quality Assurance and Social Services will do a quarterly periodicservice review of the finances to provide	03/06/2016

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	The RM indicated the staff failed to redeposit client #3's money back into his account after his 10/2015 outings. On 1/28/16 at 9:35am, client #3's record was reviewed. Client #3's 7/1/15 ISP (Individual Support Plan) and record indicated he was not able to give consent, needed staff supervision with his finances, and was not able to make purchases independently. On 1/28/16 at 11:40am, the facility's undated policy and procedure for "Finances" indicated "...Staff will count the money that is in the cash box...The amount in the cash box will be documented on the main ledger...(Staff) will distribute the money for outings, shopping, etc...The staff responsible for the consumers' money/receipts will sign the cash receipt for money taken from. Upon returning home from the purchase, the staff will give change and receipts...to return to the cash box...." On 2/5/16 at 1:35pm, an interview with the Residential Director of Operation (RDO) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The RDO indicated client personal funds accounts were kept separate for each client. The RDO indicated client #3's money in the baggie		additional administrative oversight. Recordof Training forms will be completed following staff trainings and will besubmitted to the Residential Director for administrative oversight.	

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	was not redeposited after his outings. The RDO indicated the facility's personal funds policy and procedure was not followed by the facility staff because the staff failed to return the money to client #3's secure money box after the outing. The RDO indicated the facility staff failed to follow the facility's policy and procedure for a full and accurate accounting. 9-3-2(a)			
W 0227 Bldg. 00	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. Based on interview and record review for 1 of 4 sampled clients (client #4), the client's Individual Support Plan (ISP) failed to address client #4's client to client physically aggressive behaviors and did not include any reactive and/or proactive strategies in regard to client #4's physical aggression. Client #4's ISP and/or behavior support plan (BSP) failed to indicate how facility staff was to monitor the client to prevent the client's physical aggression. Findings include:	W 0227	**W227** **Finding(s):** ***1."Basedon interview and record review for 1 of 4 sampled clients (client #4), theclients individual Support Plan (ISP) failed to address client #4's client toclient physically aggressive behaviors and did not include any reactive and/orproactive strategies in regard to client #4's physical aggression. Client #4'sISP and/or Behavior Support Plan (BSP) failed to indicate how facility staffwas to monitor the client to prevent the client's physical***	03/06/2016

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	On 1/26/16 at 1:55pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations from 5/2015 through 1/26/16 were reviewed and indicated client #4's client to client physically aggressive behaviors: -A 1/4/16 BDDS report for an incident on 1/4/16 at 8:30am indicated client #4 "yelled and spit" on client #3, then pushed client #3 resulting in a three inch (3") contusion to client #3's left temple. -An 8/28/15 BDDS report for an incident on 8/28/15 at 3:00pm indicated client #4 "slapped" another unidentified client in the left shoulder. -A 6/27/15 BDDS report for an incident on 6/26/15 at 10:10am indicated client #4 hit client #3 in the arm. -A 5/14/15 BDDS report for an incident on 5/13/15 at 1:15pm indicated client #4 became angry and "aggressive" physically with client #3. The report indicated the outing was canceled for the evening. Client #4's record was reviewed on 1/27/16 at 11:55am. Client #4's 12/10/15 ISP (Individual Support Plan) and 9/2015 BSP (Behavior Support Plan) indicated he had targeted behaviors of SIB (Self		***aggression."*** **CorrectiveAction(s):** **Toensure client #4's Behavior Support Plan (BSP) addresses the targeted behaviorof client to client physical aggression, reactive and/or proactive strategiesin regards to client #4's physically aggressive behavior, and indicates howfacility staff are to monitor the client to prevent the client's physicalaggression.** 1.TheQualified Intellectual Disabilities Professional (QIDP) will revise client #4'sBehavior Support Plan (BSP) to address the client to client physicalaggression, reactive and/or proactive strategies in regards to client #4'sphysical aggression, and indicate how facility staff are to monitor client #4to prevent client's physical aggression. Approval will be obtained from theHuman Rights Committee for the revisions made to the BSP. All staff located in thehome will be trained on the revisions made to the BSP. Record of Training formswill be completed following staff trainings and will be submitted to theResidential Director for administrative oversight.	

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	Injurious Behavior), Verbal Abuse, and Spitting. Client #4's record did not include client to client physically aggressive behaviors. Client #4's 9/2015 BSP indicated client #4 "at times [client #4] will become very abusive at times when he is agitated. He has yelled at staff and peers. He will curse at times." Client #4's BSP indicated the facility failed to specifically address the client's identified behavior of physical aggression as client #4's BSP and/or ISP did not include any additional proactive and/or reactive strategies to prevent the client's physical aggression. Client #4's 12/10/15 ISP and/or 9/15 BSP failed to indicate how facility staff was to monitor client #4 to prevent the client's physical aggression. On 2/5/16 at 1:35pm, an interview with the Residential Director of Operation (RDO) and the Qualified Intellectual Disabilities Professional (QIDP) was conducted. The RDO and QIDP both indicated client #4's ISP and BSP did not address client #4's physical aggression behaviors. When asked how the client was monitored, the QIDP and RDO both indicated staff redirect him verbally each time. The RDO and QIDP both stated client #4's physical aggression had "increased" in the past year and no corrective measures to address client #4's			

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	15G535		02/05/2016

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	behaviors had been completed. The RDO indicated client #4 was scheduled to be seen at the local mental health clinic later in the month. The RDO indicated client #4's physically aggressive behaviors were not documented in his record but were recorded as a BDDS report. The RDO indicated client #4's ISP and BSP failed to include his behavior of physical aggression and did not include any reactive and/or proactive strategies in regard to client #4's physical aggression. Client #4's ISP and/or behavior support plan (BSP) failed to indicate how facility staff was to monitor the client to prevent the client's physical aggression. 9-3-4(a)			
W 0249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review, and interview, for 3 of 4 sampled clients (clients #1, #2, and #3) and 2 additional clients (clients #5 and #6), the facility	W 0249	**W249** **Finding(s):** ***a) "Based on observation,interview and***	03/06/2016

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	failed to implement clients #1, #2, #3, #4, #5, #6, #7, and #8's Individual Support Plans (ISP) when opportunities existed. Findings include: 1. On 1/27/16 at 6:10am, GHS (Group Home Staff) #2 asked client #2 to come into the medication room, assembled client #2's supplies for her blood sugar, pricked client #2's middle finger, removed blood onto a test strip, and tested client #2's blood sugar. At 6:10am, client #2 stated "I'm a Diabetic" and no medication teaching or training regarding client #2's blood sugar was observed. Client #2's record was reviewed on 1/28/16 at 10:40am. Client #2's 5/14/15 ISP (Individual Support Plan) indicated a goal/objective to state the reason for her Metformin medication for Diabetes. 2. On 1/27/16 at 6:16am, GHS #2 selected client #3's medications, ground with a pill crusher, and dispensed client #3's medications into a medication cup including: Omeprazole for acid reflux and Ibuprofen for knee pain. GHS #2 fed the medication to client #3 and no teaching client #3 regarding his medications was observed.		***record review for 3 of 4 sampled clients (clients #1, #2, and #3)and 2 additional clients (clients #5 and #6), the facility failed to implementclients #1, #2, #3, #4, #5, #6, #7, and #8's Individual Support Plans (ISPs)when opportunities existed."*** **CorrectiveAction(s):** **Toensure client's #1, #2, #3, #4, #5, #6, #7, and #8's Individual Support Plans(ISPs) are implemented when opportunities exist.** 1.Allstaff located in the home will be retrained on all clients Individual SupportPlans (ISPs) and providing active treatment when opportunities exist throughformal and/or informal programming. Record of training forms willbe completed following staff trainings and will be submitted to the ResidentialDirector for administrative oversight.	

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	Client #3's record was reviewed on 1/28/16 at 9:35am. Client #3's 7/1/16 ISP indicated a goal/objective to write his name and to identify the aspirin pill. 3. On 1/27/16 at 6:25am, GHS #2 selected client #5's Levothyroxine medication for her Thyroid, dispensed the medication into a medication cup, and gave the medication to client #5 to consume with water. No teaching client #5 regarding her medication was observed. On 1/28/16 at 10:00am, client #5's 1/2016 medication goal/objective indicated to state the reason for Hydroxychloroquine medication for Arthritis discomfort. 4. On 1/27/16 at 6:32am, GHS #2 selected client #1's Levoxyl medication for his Thyroid, dispensed the medication into a medication cup, and gave the medication to client #1 to consume. No teaching client #1 regarding his medication was observed. At 6:35am, client #1 indicated he did not know what his Levoxyl medication was for. Client #1's record was reviewed on 1/27/16 at 10:50am. Client #1's 5/14/15 ISP indicated a goal/objective to state the reason for his Risperdal medication for			

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	behaviors. 5. On 1/27/16 at 6:37am, GHS #2 selected client #6's Levothyroxine medication for her Thyroid, dispensed the medication into a medication cup, and gave the medication to client #6 to consume. No teaching client #6 regarding her medication was observed. On 1/28/16 at 10:00am, client #6's 1/2016 medication goal/objective indicated she would sign her name for her medications. An interview was conducted on 1/27/16 at 8:05am, with GHS #2. GHS #2 indicated the facility followed Core A/Core B medication administration teaching to administer medications. GHS #2 indicated clients #1, #2, #3, #5, and #6 were not provided medication teaching at the 6am medication administration time because the clients' medication goals had specific times for staff to implement the specific goals and it was not at 6am. On 2/5/16 at 1:35pm, an interview with the RDO (Residential Director of Operations) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The RDO and the QIDP both indicated clients #1, #2, #3, #5, and #6's ISP objectives/goals should be			

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	implemented by the facility staff during formal and informal opportunities. The RDO indicated the facility staff should teach the clients the names, reasons, and doses of the medications each client was administered when opportunities existed. The RDO indicated client #2 should be taught regarding her blood sugar during informal opportunities. 9-3-4(a)			
W 0268 Bldg. 00	483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation, interview, and record review, for 3 of 3 sampled male clients (clients #1, #3, and #4) and 1 additional client (client #7), the facility failed to ensure clients #1, #3, #4, and #7's dignity in regard to hair cuts. Findings include: On 1/26/16 from 3:50pm until 6:05pm and on 1/27/16 from 5:55am until 8:45am, clients #1, #3, #4, and #7 were observed at the group home and had hair over their ears and down the backs of their necks covering their necks from the	W 0268	**W268** **Finding(s):** ***1."Based on interview and record review for 3of 3 sampled male clients (clients #1, #3 and #4) and 1 additional client(client #7), the facility failed to ensure clients #1, #3, #4, and #7's dignityin regard to haircuts."*** **CorrectiveAction(s):** **Toensure that clients #1, #3, #4, and #7 receive haircuts to protect theirdignity.** 1.TheResidential House Manager will ensure that the dignity of clients #1, #3, #4,and	03/06/2016

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	top of their heads to their backs inside their shirt collars. On 1/26/16 at 5:40pm, male clients #1, #3, #4, and #7 indicated they wanted their hair cut. At 5:40pm, client #1 stated "I like it short, too long" now. At 5:40pm, client #3 stated his hair was "too long." Clients #1, #3, #4, and #7 indicated they did not recall when they had their last hair cut. On 1/26/16 at 5:50pm, an interview with the RM (Residential Manager) and GHS (Group Home Staff) #3 both indicated clients #1, #3, #4, and #7 had long hair, had long hair on their necks, and their last hair cut had been during the month of August, 2015. Both indicated the beautician had been unavailable and clients #1, #3, #4, and #7's hair had not been cut and/or groomed. Both indicated not having their hair cut was a dignity issue. Client #1's record was reviewed on 1/27/16 at 10:50am. Client #1's record did not indicate when he last had his hair cut or groomed. Client #3's record was reviewed on 1/28/16 at 9:35am. Client #3's record did not indicate when he last had his hair cut or groomed. Client #4's record was reviewed on 1/27/16 at 11:55am. Client #4's record did not indicate when he last had his hair		#7's dignity is protected in regards to haircuts. Haircuts will be offeredmonthly. All haircuts will be documented in the daily notes. The ResidentialDirector of Quality Assurance and Social Services will do a Periodic ServiceReview quarterly and monitor that haircuts are being provided.	

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	cut or groomed. On 2/5/16 at 1:35pm, an interview with the Residential Director of Operation (RDO) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The RDO and QIDP indicated clients #1, #3, #4, and #7 had been assisted to schedule appointments in the community to get their hair cut when the client's hair needed cut/groomed. The RDO indicated she was unaware clients #1, #3, #4, and #7 had not been to obtain a hair cut since 8/2015. The RDO stated hair cuts were usually completed "about every four to six weeks." 9-3-5(a)			
W 0323 Bldg. 00	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. Based on record review and interview, for 1 of 4 sampled clients (client #2), the facility failed to include an assessment of client #2's visual needs as recommended and/or during her annual history and physical. Findings include:	W 0323	**W323** **Finding(s):** ***1."Based on observation, interview and recordreview for 1 of 4 sampled clients (client #2), the facility failed to includean assessment of client #2's visual needs as recommended and/or during herannual history and physical."*** **CorrectiveAction(s):**	03/06/2016

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	Client #2's record was reviewed on 1/28/16 at 10:40am. Client #2's record indicated an 10/1/15 annual history and physical which did not assess and/or screen her visual needs. Client #2's 11/20/13 visual evaluation indicated a recommendation to be re evaluated "every 2 yrs. (years)." On 2/5/16 at 1:35pm, an interview was conducted with the Residential Director of Operations (RDO). The RDO indicated client #2's visual screening/evaluation was not available for review. The RDO indicated the agency had made a change in its nursing staff because follow up to medical issues was not being completed. The RDO indicated no further documentation was available for review. 9-3-6(a)		**Toensure that client #2's visual needs are addressed and maintained:** 1.TheResidential Nurse will ensure that the visual needs of #2 is addressed andmaintained as per doctor orders and recommendations. The Residential nurse willensure that client #2 is seen by the vision doctor. The Residential Director ofQuality Assurance and Social Services will do a quarterly Periodic ServiceReview and will audit and monitor that vision appointments are scheduledaccordingly to the needs of the client and all recommendations and orders arebeing followed and implemented.	
W 0327 Bldg. 00	483.460(a)(3)(iv) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the American Academy of Pediatrics, or both. Based on interview and record review, for 4 of 4 sampled clients (clients #1, #2,	W 0327	**W327** **Finding(s):** ***1."Basedon interview and***	03/06/2016

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	#3, and #4), the facility failed to complete client #1, #2, #3, and #4's Mantoux (tuberculin skin test) and/or screening. Findings include: Client #1's record was reviewed on 1/27/16 at 10:50am. Client #1's 11/13/14 "Mantoux" indicated "zero" millimeters (mm). Client #1's 9/29/15 physician's visit did not include a tuberculin skin test or screening. Client #2's record was reviewed on 1/28/16 at 10:40am. Client #2's 11/13/14 "Mantoux" indicated "zero" millimeters (mm). Client #2's 10/1/15 physician's visit did not include a tuberculin skin test or screening. Client #3's record was reviewed on 1/28/16 at 9:35am. Client #3's 11/13/14 "Mantoux" indicated "zero" millimeters (mm). Client #3's 8/12/15 physician's visit did not include a tuberculin skin test or screening. Client #4's record was reviewed on 1/27/16 at 11:55am. Client #4's 11/13/14 "Mantoux" indicated "zero" millimeters (mm). Client #4's 10/8/15 physician's visit did not include a tuberculin skin test or screening.		***record review for 4 of 4 sampled clients (clients #1, #2, #3,and #4), the facility failed to complete client #1, #2, #3, and #4's Mantoux(Tuberculin skin test) and/or screening. "*** **CorrectiveAction(s):** **Toensure that all clients receives there annual Mantoux (Tuberculin skin test)and/or screening annually:** 1.TheResidential Nurse will ensure that client' #1, #2, #3, and #4's Mantoux(tuberculin skin test) and/or screening is completed. The Residential Nursewill ensure that all clients receive an annual Mantoux (Tuberculin skin test)annually. The Residential Director of Quality Assuranceand Social Services will do a quarterly Periodic Service review and ensure thatclients annual Mantoux (tuberculin skin test) is current to give administrativeoversight.	

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	On 2/5/16 at 1:35pm, an interview with the Residential Director of Operations (RDO) was conducted. The RDO indicated clients living in the group home should receive a yearly Mantoux/Tuberculin skin test and/or a tuberculosis screening. The RDO indicated no further information was available for review. 9-3-6(a)			
W 0331 Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review, and interview, for 2 of 4 sampled clients (clients #1 and #4), the facility's nursing services failed to ensure client #1's PSA (Protein produced by cells of the prostate gland and measures the level in a man's blood) was completed and failed to develop protocols specific to client #4's recurrent eye infections from SIB (Self Injurious Behaviors). Findings include: 1. Client #1's record was reviewed on 1/27/16 at 10:50am. Client #1's record indicated an 10/13/14 PSA (Protein produced by cells of the prostate gland and measures the level in a man's blood)	W 0331	**W331** **Finding(s):** ***1."Based on interview and record reviewfor 2 of 4 sampled clients (clients #1 and #4), the facility's nursing servicesfailed to ensure client #1's PSA (Protein produced by cells of the prostategland and measures the level in a man's blood) was completed and failed todevelop protocols specific to client #4's recurrent eye infections from SIB(self-injurious behaviors)."*** **CorrectiveAction(s):** **Toensure that the facilities nursing services provide clients the services thatmeet their needs:**	03/06/2016

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	test result and a 9/29/15 physician's recommendation to have a PSA test completed every year. No current PSA test was available for review. On 2/5/16 at 1:35pm, an interview was conducted with the Residential Director of Operations (RDO). The RDO indicated client #1's current PSA testing was not available for review. The RDO indicated the agency had made a change in its nursing staff because follow up to medical issues was not being completed. The RDO indicated no further documentation was available for review. 2. On 1/26/16 from 3:50pm until 6:05pm and on 1/27/16 from 5:55am until 8:45am, client #4 was observed with the group home staff. During the observation periods client #4 rubbed his face and eyes without redirection from the facility staff. Client #4's record was reviewed on 1/27/16 at 11:55am. Client #4's 12/10/15 ISP (Individual Support Plan) and 9/2015 BSP (Behavior Support Plan) indicated he had targeted behaviors of SIB (Self Injurious Behavior) putting his fingers into his eyes, Verbal Abuse, and Spitting. Client #4's record did not include specific interventions for client #4's SIB behaviors of putting his fingers into his		1.The Residential Nurse will take client #1 to gethis PSA completed. The Residential Director of Quality Assurance and SocialServices will do a quarterly Periodic Service review and audit nursing servicesto ensure doctor orders and recommendations are being followed and implemented. 2.The Residential Nurse will implement aself-injurious risk plan that addresses client #4's recurrent eye infectionsfrom his self-injurious behaviors. All staff located in the home will betrained on the Self-injurious risk plan for clients #4. Record of Trainingforms will be completed following staff trainings and will be submitted to theResidential Director for administrative oversight.	

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	eyes. Client #4's 9/2015 BSP indicated client #4 had caused injuries to his eyes and "recurrent" eye infections resulted from client #4's SIB behaviors. Client #4's BSP indicated the facility failed to include proactive and/or reactive strategies to prevent the client's SIB of putting his fingers into his eyes. Client #4's 12/10/15 ISP and/or 9/15 BSP failed to indicate how facility staff was to monitor client #4 to prevent the client's SIB of putting his fingers into his eyes. Client #4's 11/15, 8/28/15, 5/29/15, and 2/15 Nursing Quarterlies did not include client #4's recurrent eye infections caused from his SIB. Client #4's physician's visits indicated client #4 was seen by a physician and/or an eye physician for eye infections from SIB on 9/17/15, 9/1/15, 8/25/15, 5/12/15, 4/21/15, and 4/10/15. On 2/5/16 at 1:35pm, an interview with the Residential Director of Operation (RDO) and the Qualified Intellectual Disabilities Professional (QIDP) was conducted. The RDO and QIDP both indicated client #4's ISP and BSP did not address client #4's SIB of putting his fingers into his eyes causing infections. When asked how the client was monitored, the QIDP and RDO both indicated staff redirect him verbally each time. The RDO and QIDP both stated client #4's SIB was addressed in his BSP			

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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
	but interventions specific to his putting his fingers into his eyes causing infections was not. The RDO indicated client #4 was scheduled to be seen at the local mental health clinic later in the month. The RDO indicated client #4's ISP and BSP included his SIB behavior of putting his fingers into his eyes and did not include any reactive and/or proactive strategies in regard to client #4's SIB of putting his fingers into his eyes. Client #4's ISP and/or behavior support plan (BSP) failed to indicate how facility staff was to monitor the client to prevent the client's SIB. The RDO indicated the nurse had not addressed client #4's SIB behaviors of causing injuries to himself and had not developed nursing measures to assist in preventing client #4's continued SIB resulting in eye infections. 9-3-6(a)			
W 0369 Bldg. 00	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review, and interview, for 1 of 14 medications administered during the 7:00am medication administration (client #1), the	W 0369	**W369** **Finding(s):** ***1."Basedon interview and record review for 1 of 14 medications administered***	03/06/2016

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NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1901 W GOLDEN HILLS DR PERU, IN 46970	

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	facility failed to ensure client #1's medication was given without error. Findings include: On 1/27/16 at 7:40am, client #1 was asked by GHS (Group Home Staff) #2 to come into the medication room. At 7:40am, GHS #2 selected client #1's "Polyethylene Glycol 3350 (Miralax Powder), take 1 capful (or) 17gm (grams) in 8oz (ounces) of fluid twice daily" for constipation. GHS #2 compared the medication label to client #1's 1/2016 MAR (Medication Administration Record), selected the medication container's clear plastic cap which had a line half way up the side of the cap to indicate 17 grams, poured the medicated powder to the top of the clear plastic cap measuring approximately 34 grams of medication, mixed the medication with water, and client #1 drank the medication mixture. Client #1's record was reviewed on 1/27/16 at 10:50am. Client #1's 1/7/16 Physician's Order indicated "Polyethylene Glycol 3350 (Miralax Powder), take 1 capful (or) 17gm (grams) in 8oz (ounces) of fluid twice daily" for constipation. On 2/4/16 at 11:35am, the facility's 4/2011 policy and procedures for		***during the7:00am medication administration (client#1), the facility failed to ensureclient #1's medication was given without error."*** - **CorrectiveAction(s):** **Toensure that the facilities medication administration policy and procedures arebeing implemented and followed without error:** 1.All staff located in the home will be retrainedon Bona Vista's Medication Administration Policy. Record of Training forms willbe completed following staff trainings and will be submitted to the ResidentialDirector for administrative oversight.	

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	"Medication Administration" indicated "Check the information on the pharmacy medication label by comparing it to the medication administration record and the physician's order, for the individual's name, medication ordered, dosage...Check the medication listed on the medication administration record with the medication label three times...." The policy and procedure indicated staff should administer client medications according to physician's orders and the pharmacy instructions should be followed. On 2/4/16 at 11:35am, the 2004 "Core A/Core B Medication Training" indicated "Lesson 3 Principles of Administering Medications." The Core A/Core B policy and procedure indicated the facility should follow physician orders and the pharmacy instructions. On 1/27/16 at 9:15am, an interview with the Residential Manager (RM) was conducted. The RM indicated the facility had an opening for a nurse currently. The RM indicated staff should administer medications according to physician's orders. The RM indicated staff did not follow the medication administration policy and procedure when medications were not administered according to physician's orders. The RM indicated			

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	client #1 should have been given 17 grams of Miralax medication or half a capful of the medication on 1/27/16. 9-3-6(a)			
W 0436 Bldg. 00	483.470(g)(2) SPACE AND EQUIPMENT 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, for 1 of 4 sampled clients (client #4), the facility failed to teach and encourage client #4 to wear his prescribed hearing aids. Findings include: On 1/26/16 from 3:50pm until 6:05pm and on 1/27/16 from 5:55am until 8:45am, client #4 was not observed to wear his prescribed hearing aids. During both observation periods client #4 colored on paper, ate meals, completed medication administration, dressed, shaved, and watched other clients. During both observation periods facility staff were not observed to teach and encourage client #4 to wear his prescribed hearing aids.	W 0436	**W436** **Finding(s):** ***1."Basedon interview, observation, and record review for 1 of 4 sampled clients (client#4), the facility failed to teach and encourage client #4 to wear hisprescribed hearing aids."*** **CorrectiveAction(s):** **Toensure that facility staff teach and encourage client #4 to wear his prescribedhearing aids:** 1.All staff located in the home will be retrainedon Client #4's hearing aid risk plan and in using informal and/or formalprogramming to teach and encourage client #4 to wear his prescribed hearingaid. Record of Training forms will be completed following staff trainings andwill be	03/06/2016

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	Client #4's record was reviewed on 1/27/16 at 11:55am. Client #4's 11/11/15 hearing evaluation indicated client #4 had "impaired hearing" and needed his hearing aids. Client #4's 12/10/15 ISP (Individual Support Plan) indicated a goal/objective to wear his prescribed hearing aids. On 2/5/16 at 4:00pm, the RDO provided client #4's 1/2016 "Hearing Aid Program" data sheet. The record indicated on 1/26/16 client #4 refused his "daily" hearing aid prompt to wear his aids. The record indicated on 1/27/16 the data sheet was blank to indicate client #4 was not prompted by staff to wear his hearing aids. On 2/5/16 at 1:35pm, an interview with the Residential Director of Operation (RDO) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The RDO and QIDP indicated client #4 wore prescribed hearing aids and the RDO stated client #4 "often" refuses to wear his aids. The QIDP and RDO both indicated client #4 should be prompted and encouraged by the facility staff to wear his prescribed hearing aids. 9-3-7(a)		submitted to the Residential Director for administrative oversight.	

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W 0454 Bldg. 00	483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. Based on observation, record review, and interview, for 1 of 1 sampled client (client #3) who used a pill crusher for medications, the facility failed to follow Universal Precautions for client #3's soiled pill crushers stored as clean. Findings include: On 1/27/16 from 5:55am until 8:45am, observation and interviews were completed at the group home. There was a clear pill crusher with a blue end cap which had a white powdered residue on the inside of the pill crusher. The soiled pill crusher sat on the staff table in the office and was stored available for use as clean. At 6:16am, GHS (Group Home Staff) #2 asked client #3 to come to the medication room. GHS #2 selected the blue capped pill crusher on the staff table inside the medication room, uncapped the pill crusher, GHS #2 indicated there was a white colored fine powder residue inside the base container of the pill crusher, GHS #2 inserted client #3's oral tablet	W 0454	**W454** **Finding(s):** ***1."Basedon interview and record review for 1 of 1 sampled client (client #3), who useda pill crusher for medication, the facility failed to follow UniversalPrecautions for client #3's pill crusher."*** **CorrectiveAction(s):** **Toensure that Universal Precautions are being implemented and followed for allclients. To ensure client #3 has a clean and appropriate pill crusher to use:** 1.All staff located in the home will be retrainedon Universal Precautions (in regards to the cleanliness of client #3's pillcrusher) . Record of Training forms will be completed following staff trainingsand will be submitted to the Residential Director for administrative oversight. 2.The Residential House Manager will obtain anappropriate pill crusher for client #3 and ensure that it is kept clean and ingood working order.	03/06/2016

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	medication, ground the tablets, and administered the crushed medication to client #3. GHS #2 recapped the soiled pill crusher and replaced it on the staff table. At 6:25am, GHS #2 indicated the pill crusher was washed when it was soiled but did not wash the pill crusher. At 9:40am, the blue soiled pill crusher sat on the staff table inside the medication room stored as clean. The RM (Residential Manager) indicated the pill crusher on the table was clean and available for use. On 2/5/16 at 1:35pm, an interview and record review with the Residential Director of Operations (RDO) and the Qualified Intellectual Disabilities Professional (QIDP) was conducted. The RDO and QIDP both indicated facility staff should have followed Core A/Core B medication training manual, dated 2004, for Universal Precautions. On 2/5/16 at 1:35pm, the Core A/Core B Medication Administration training manual page 3 indicated "Universal precautions should also be used when cleaning personal items...." No specific facility policy nor procedure was available for review for the care and cleaning of the pill crushers. The RDO indicated client #3's pill crushers should have been clean and free of debris.			

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	9-3-7(a)			
W 0455 Bldg. 00	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation, interview, and record review, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 4 additional clients (clients #5, #6, #7, and #8), the facility failed to teach and encourage clients #1, #2, #3, #4, #5, #6, #7, and #8 to wash their hands when opportunities existed. Findings include: On 1/27/16 from 5:55am until 8:45am, clients #1, #2, #3, #4, #5, #6, #7, and #8 were observed at the group home. From 5:55am until 7:20am, clients #1, #2, #3, #4, #5, #7, and #8 were not observed to wash their hands. At 7:05am, clients #1, #2, #3, #4, #5, #7, and #8 began to eat their breakfast cereal and no handwashing was observed. From 5:55am until 7:20am, clients #1, #2, #3, #4, #5, #7, and #8 completed their morning care, brushed their hair, dressed, changed the television channels with the remote control, dressed, and did not wash their hands. At 6:16am, GHS (Group Home Staff) #2 administered client #3's	W 0455	**W455** **Finding(s):** ***1."Basedon interview and record review for 4 of 4 sampled clients (clients #1, #2, #3,and #4) and 4 additional clients (clients #5, #6, #7, and #8), the facilityfailed to teach and encourage clients #1, #2. #3, #4, #5, #6, #7, and #8 towash their hands when opportunities existed."*** - **CorrectiveAction(s):** **Toensure that all facility staff uses formal and/or informal programming andactive treatment when opportunities exist for all clients in the group home towash their hands:** 1.All staff located in the home will be retrainedon active treatment through using formal and/or informal programming to teachand encourage all clients in the home to wash their hands when opportunitiesexist. Record of Training forms will be completed following staff trainings andwill be submitted to the Residential Director for administrative oversight.	03/06/2016

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	medications and no handwashing was encouraged. From 6:55am until 7:20am, client #4 took his shoes off and on while seated at the dining room table, client #4 chewed on his shoestring without redirection, and client #4 was not encouraged to wash his hands. At 7:20am, client #6 licked her fingers after setting the scrambled egg container on the dining room table, wiped debris from her dining room chair with her hand, and was not prompted to wash her hands. From 7:05am until 7:20am, clients #1, #2, #3, #4, #5, #6, #7, and #8 fed themselves toast, scrambled eggs, and cereal and did not wash their hands. On 2/5/16 at 1:35pm, the facility's undated policy and procedures for "Handwashing" and infection control were reviewed and indicated "All persons who are served...are to wash hands before and after providing personal care to an individual and before preparing, serving, or eating food." On 2/5/16 at 1:35pm, an interview and record review with the Residential Director of Operations (RDO) and the Qualified Intellectual Disabilities Professional (QIDP) was conducted. The RDO and QIDP both indicated facility staff should have followed Core A/Core B medication training manual, dated		2.All staff located in the home will be retrainedon hand washing. Record of Training forms will be completed following stafftrainings and will be submitted to the Residential Director for administrativeoversight. 3.All clients in the home have informal programgoals in place for hand washing. All staff located in the home will beretrained on all client's informal hand washing goals. Record of Training formswill be completed following staff trainings and will be submitted to theResidential Director for administrative oversight.	

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	2004, for Universal Precautions. On 2/5/16 at 1:35pm, the Core A/Core B Medication Administration training manual indicated clients should wash their hands before and after dining. 9-3-7(a)			
W 0475 Bldg. 00	483.480(b)(2)(iv) MEAL SERVICES Food must be served with appropriate utensils. Based on observation and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 4 additional clients (clients #5, #6, #7, and #8), the facility failed to have serving dishes, regular plates, and standard utensils available for use during dining opportunities. Findings include: On 1/27/16 from 5:55am until 8:45am, clients #1, #2, #3, #4, #5, #6, #7, and #8 were observed at the group home. From 6:40am until 7:20am, GHS (Group Home Staff) #4 was in the kitchen with client #6 making scrambled eggs and preparing breakfast. GHS #4 prompted clients #1, #2, #6, and #7 to assist with breakfast. At 7:05am, GHS #4 asked clients to set the table for breakfast and clients #1, #2, #6, and #7 retrieved plastic foam disposable plates, a plastic fork, a plastic	W 0475	**W475** **Finding(s):** ***1."Basedon interview and record review for 4 of 4 sampled clients (clients #1, #2, #3,and #4) and 4 additional clients (clients #5, #6, #7, and #8), the facilityfailed to have serving dishes, regular plates, and standard utensils availablefor use during dining opportunities."*** - **CorrectiveAction(s):** **Toensure that there are serving dishes, regular plates, and standard utensilsavailable for use during dining opportunities:** 1.All staff located in the home will beretrained on Family Style Dining. Record of Training forms will becompleted following staff trainings and will be submitted to the ResidentialDirector for	03/06/2016

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	spoon, and placed them on the table at each of the eight (8) place settings. At 7:05am, clients #1, #2, and #6 stated they "used plastic all the time" to eat with for meals. Client #1 stated "We use the regular plates when we run out of plastic" and GHS #4 shook his head yes. At 7:05am, clients #7 and #8 stated "When we're out of the paper plates and plastic silverware, we then use the regular" dishware and flatware. At 7:05am, GHS #4 prompted client #6 to retrieve a serving container for the hot scrambled eggs. Client #6 removed a clear plastic glad ware container, GHS #4 indicated to client #6 that was an acceptable container, and client #6 and GHS #4 scraped the scrambled eggs from the skillet off the stove into the plastic glad ware container. Client #6 carried the eggs to the dining room table. At 7:20am, GHS #4 looked through the kitchen cabinets and indicated the facility had no serving bowls available for use at the group home. On 2/5/16 at 1:35pm, an interview with the Residential Director of Operation (RDO) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The RDO and QIDP indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 should use regular dishes, standard utensils, and serving dishes at		administrative oversight. 2.The Residential House Manager will ensure thereis an appropriate amount of serving dishes, regular plates, and standardutensils in the home for use.	

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	the group home. The RDO indicated she was not aware the group home did not have serving dishes available for use. 9-3-8(a)			
W 0488 Bldg. 00	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. Based on observation and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 4 additional clients (clients #5, #6, #7, and #8), the facility failed to teach and encourage clients #1, #2, #3, #4, #5, #6, #7, and #8 to prepare their own lunches when opportunities existed. Findings include: On 1/27/16 from 5:55am until 8:45am, observation and interview were completed at the group home and eight (8) clear plastic gallon size bags were filled with a prepared sandwich, fruit cup, pre bagged chips, and pre bagged cookie. The eight bags lay on the kitchen counter; GHS (Group home staff) #4 indicated he had prepared and packed the lunches for each client. On 2/5/16 at 1:35am, an interview with the RDO (Residential Director of	W 0488	**W488** **Finding(s):** ***1."Basedon interview and record review for 4 of 4 sampled clients (clients #1, #2, #3,and #4) and 4 additional clients (clients #5, #6, #7, and #8), the facilityfailed to teach and encourage clients #1, #2, #3, #4, #5, #6, #7, and #8 toprepare their own lunches when opportunities exist."*** **CorrectiveAction(s):** **Toensure that all clients in the home are taught and encouraged to assist in mealpreparation when opportunities exist:** 1.The Qualified Intellectual DisabilitiesProfessional (QIDP) will ensure that all clients in the home has a formal orinformal goal for meal preparation for lunches. All staff located in the homewill be trained on the new or	03/06/2016

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	Operations) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The RDO and QIDP both indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 should prepare and pack their own lunches when opportunities exist. 9-3-8(a)		revised goals. . Record of Training formswill be completed following staff trainings and will be submitted to theResidential Director for administrative oversight. 2.A All staff located in the home will beretrained on active treatment through using formal and/or informal programmingto teach and encourage all clients in the home to assist in preparation oftheir lunches when opportunities exist. Record of Training forms will becompleted following staff trainings and will be submitted to the ResidentialDirector for administrative oversight.	