

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G586		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/22/2012	
NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904			
(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			
W0000	<p>This visit was for a pre-determined full recertification and state licensure survey.</p> <p>Dates of survey: October 17, 18, 19, 22, 2012.</p> <p>Facility Number: 001100 Provider Number: 15G586 AIM Number: 100240050</p> <p>Surveyor: Susan Reichert, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/30/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000					

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

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/22/2012
NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904		
(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	
W0149	<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, the facility neglected to implement policy and procedures to protect 1 of 4 sampled clients (client #4) from seclusion, and failed to document a thorough investigation for 1 of 1 allegation of potential abuse and neglect involving client #4.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and internal incident reports were reviewed on 10/17/12 at 4:05 PM. A report dated 7/2/12 indicated staff #7 had raised her voice to client #4 and pulled her in her wheelchair into the bathroom "during a behavior" and held the bathroom door.</p> <p>The Residential Director was interviewed on 10/17/12 at 4:00 PM. The Director indicated the allegation was substantiated and staff #7 was terminated.</p> <p>During observations at the group home on 10/17/12 from 4:30 PM to 6:44 PM, client #4 nodded yes to questions asked of</p>	W0149	<p>Staff #7 had been trained on agency policy and client #4 behavior plan. Staff #7's actions were a violation of client #4's rights and against agency policy- therefore she was terminated. All QDDP's and House Manager's were retrained and are aware of how to complete a thorough investigation. Whenever an allegation is made, staff will use the internal investigation form and attach to the BDDS incident report along with staff and consumer statements. Since this incident, staff have been trained on a monthly basis on the agency's abuse/neglect policy and the importance of immediately reporting to supervisor any suspicious activity. The House Manager works various shifts to monitor staff interactions. The House Manager completes one on one meetings with staff to discuss performance and provide opportunity to talk about any issues the staff feel need addressed. A Lead Direct Support Professional was hired following the incident to monitor the actions of staff when the House Manager is not present. Client #4 has a communication goal to discuss events of the day.</p>	11/06/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G586		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/22/2012	
NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904			
(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			
	<p>her by staff, and indicated she wanted the house manager to sit by her during the evening meal. Client #4 had a ring of communication pictures on the back of her wheelchair, but didn't use them during the observation when she interacted with staff.</p> <p>An Investigation of Alleged Neglect, Battery, Exploitation or Physical Abuse dated 7/2/12 was reviewed on 10/18/12 at 11:20 AM and indicated "It appears that [staff #7] was not appropriate in how she communicated to [client #4]. The allegation of the holding of the bathroom door is the most serious allegation in this investigator's opinion and it appears under all of the circumstances and seemingly truthful witnesses that [staff #7] did hold the door shut to keep [client #4] inside of it." A statement written by the investigator indicated staff #7 indicated she had raised her voice to client #4 because of her proximity to client #4 across the room from her. Staff #7 indicated she had moved client #4 in her wheelchair to protect another client as client #4 was throwing items. The investigator indicated in the written investigation client #4 was "unable to communicate what happened due to her being essentially non-verbal." A statement by staff #9 indicated staff #7 "dragged" client #4's wheelchair to the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G586		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/22/2012	
NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904			
(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			
	<p>bathroom and placed her in the bathroom without a light. She indicated when she went to the bathroom client #4 was crying. A statement by staff #10 indicated client #4 was upset about a birthday and staff #7 told her it wasn't her birthday, and indicated she was going to school, then stated, "Are you done with your fit?," client #4 said "yes." A statement by staff #6 indicated staff #7 "aggressively" pushed client #4 into the bathroom, stated, "I'm not dealing with this," and held the door shut while client #4 was screaming and yelling. Individual witness statements regarding the events of the incident from client #4 and staff #7 were not included in the investigation.</p> <p>The Residential Director was interviewed on 10/18/12 at 11:20 AM and indicated the allegation staff #7 held the door shut was substantiated. She indicated client #4 was able to talk, but unable to convey what happened. She indicated client #4 was unable to answer open ended questions and if asked if someone was mean to her, might not answer truthfully and based upon her perception. The Director indicated staff #7's statement would be included in personnel records, and she was terminated after the allegation of abuse and neglect was substantiated.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G586		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/22/2012	
NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904			
(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			
	<p>Staff #7's personnel records were reviewed on 10/19/12 at 12:10 PM. A 7/11/12 Employee Warning Notice included a written statement from staff #7, "I did not do what I am accused of and believe my termination is unlawful. I would NEVER treat a consumer with neglect...." There was no additional statement or documentation that included staff #7's account of the incident on 7/2/12.</p> <p>The Residential Director and Residential Coordinator were interviewed on 10/22/12 at 12:23 PM and indicated client #4 is able to answer yes and no questions and would be able to respond with yes or no answers if interviewed regarding the incident on 7/2/12. The Residential Director indicated staff #4 was in violation of the agency's policy in regards to the use of seclusion and for emotional/verbal abuse.</p> <p>The facility's Prohibition of Violations of Individual Rights dated 5/11 was reviewed on 10/18/12 at 12:00 PM. The document indicated the agency "strictly prohibits the abuse of any form, neglect, exploitation or mistreatment of an individual or violation of the individual's rights by employees or agents delivering services on behalf of the agency...Seclusion: Involuntary</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/22/2012
NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904		
(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	
	<p>placement in a room or area alone from which exit is prohibited...Practices prohibited by this policy include: ...Seclusion by placing an individual alone in a room or other area from which exit is prevented..Emotional/Verbal abuse including but not limited to communicating with words or actions in a persons presence with an intent to: cause the person to be placed in fear of confinement or restraint; cause the individual to experience emotional distress or humiliation; cause others to view the individual with hatred, contempt, disgrace or ridicule; cause the individual to react in a negative manner...."</p> <p>9-3-2(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G586		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/22/2012	
NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904			
(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			
W0154	<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 for 1 of 3 allegations of abuse to document a thorough investigation of an allegation of potential abuse and neglect involving 1 of 4 sampled clients (client #4).</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and internal incident reports were reviewed on 10/17/12 at 4:05 PM. A report dated 7/2/12 indicated staff #7 had raised her voice to client #4 and pulled her in her wheelchair into the bathroom "during a behavior" and held the bathroom door in an attempt to not let client #4 out.</p> <p>The Residential Director was interviewed on 10/17/12 at 4:00 PM. The Director indicated the allegation was substantiated and staff #7 was terminated.</p> <p>During observation at the group home on 10/17/12 from 4:44 PM until 6:44 PM, client #4 nodded yes to questions asked of her by staff, and indicated she wanted the</p>	W0154	Whenever an allegation is made, staff will use the internal investigation form and attach to the BDDS incident report along with staff statements. Copies of the staff statements along with the BDDS report and investigation notes are also maintained in the employee file located in Human Resources. On 10/30/12 all QDDP's and House Manager's were retrained and are aware of how to complete a thorough investigation.	10/30/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G586		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/22/2012	
NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904			
(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			
	<p>house manager to sit by her during the evening meal. Client #4 had a ring of communication pictures on the back of her wheelchair, but didn't use them during the observation.</p> <p>An Investigation of Alleged Neglect, Battery, Exploitation or Physical Abuse dated 7/2/12 was reviewed on 10/18/12 at 11:20 AM indicated "It appears that [staff #7] was not appropriate in how she communicated to [client #4]. The allegation of the holding of the bathroom door is the most serious allegation in this investigator's opinion and it appears under all of the circumstances and seemingly truthful witnesses that [staff #7] did hold the door shut to keep [client #4] inside of it." A statement written by the investigator indicated staff #7 indicated she had raised her voice to client #4 because of her proximity to client #4 across the room from her. Staff #7 indicated she had moved client #4 in her wheelchair to protect another client as client #4 was throwing items. The investigator indicated client #4 was "unable to communicate what happened due to her being essentially non-verbal." Individual witness statements regarding the events of the incident from client #4 and staff #7 were not included in the investigation.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G586		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/22/2012	
NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904			
(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			
	<p>The Residential Director was interviewed on 10/18/12 at 11:20 AM and indicated the allegation staff #7 held the door shut was substantiated. She indicated client #4 was able to talk, but unable to convey what happened. She indicated client #4 was unable to answer open ended questions and if asked if someone was mean to her, might not answer truthfully and based upon her perception. The Director indicated staff #7's statement would be included in personnel records, and she was terminated after the allegation of abuse and neglect was substantiated.</p> <p>Staff #7's personnel records were reviewed on 10/19/12 at 12:10 PM. A 7/11/12 Employee Warning Notice included a written statement from staff #7, "I did not do what I am accused of and believe my termination is unlawful. I would NEVER treat a consumer with neglect...." There was no additional statement or documentation that included staff #7's account of the incident on 7/2/12.</p> <p>The Residential Director and Residential Coordinator were interviewed on 10/22/12 at 12:23 PM and indicated client #4 is able to answer yes and no questions and would be able to respond with yes or no answers if interviewed regarding the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/22/2012
NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904		
(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	
	incident on 7/2/12. 9-3-2(a)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/22/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904
---	---

(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
W0210	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on interview and record review for 1 of 4 sampled clients (client #3), the facility failed to provide assessments of speech and language development, sensory motor development and physical development, and failed to assess client #3's vision within 30 days of admission.</p> <p>Findings include:</p> <p>Client #3's records were reviewed on 10/18/12 at 2:58 PM. The record indicated client #3 had been admitted on 6/15/12. There was no evidence in the record of a speech, occupational therapy, or physical therapy assessment. There was no evidence of an evaluation of client #3's vision since 5/31/11.</p> <p>The group home nurse was interviewed on 10/18/12 at 10/18/12 at 3:09 PM. She indicated client #3 had not had a speech and language, physical therapy, occupational therapy assessment since his admission. She indicated client #4 had not had a more recent evaluation of his vision since 5/31/11.</p>	W0210	The QDDP and nurse will assess clients needs and ensure all necessary medical appointments and evaluations have been completed within 30 days of admittance. Client #3's hearing evaluation was completed on 10/11/12, Eye exam is scheduled for 11/20/12, Speech evaluation is scheduled for 11/28/12 and OT/PT eval is scheduled for 12/4/ 12. The Periodic Service Review is a quality assurance tool to check that necessary medical appointments, documents, etc are completed in a timely manner. The PSR is completed by the Director of Ancillary Services. Results of the PSR are forwarded to the QDDP and Director of Residential Services.	12/04/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/22/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904
---	---

(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
	9-3-4(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G586		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/22/2012	
NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904			
(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			
W0217	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include nutritional status. Based on interview and clinical record review for 1 of 4 sampled clients (client #2), the facility failed to assess her needs in the area of dining.</p> <p>Findings include:</p> <p>Observations were completed in the group home on 10/17/12 from 4:47 PM to 6:44 PM. Client #2 required staff physical assistance to eat with an unaltered table fork. There was no evidence of adapted utensils during client #2's meal.</p> <p>Client #2's record was reviewed on 10/18/12 at 2:10 PM. There was no evidence of an assessment of client #2's dining needs. Nursing notes dated 12/4/08 indicated client #2 had been evaluated by an occupational therapist. The therapist had provided client #2 with red foam tubes to put on her utensils to assist her with grip and "they appeared to be very effective."</p> <p>The group home nurse was interviewed on 10/18/12 at 1:25 PM. She indicated there was no evidence of client #2's occupational therapy assessment on 12/4/08, and when asked if client #2 was to be using the tubes on her utensils, she</p>	W0217	Client #2 has an evaluation scheduled for 12 /4/12. The QDDP and nurse will assess clients needs on a regular basis to ensure all necessary evaluations have been completed per guidelines and staff are following recommendations. Staff have been retrained on the importance of using all adaptive equipment as recommended (eye glasses, braces, hand grippers, etc). Client #2 will have a goal based on the results of the OT evaluation.	12/04/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/22/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904
---	---

(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
	<p>stated, "Yes, I think so." She indicated client #2 had not been re-evaluated for her dining needs, and client #2 needed staff assistance with dining.</p> <p>9-3-4(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G586		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/22/2012	
NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904			
(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			
W0227	<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 interview and record review for 1 of 4 sampled clients (client #3), the Individual Support Plan (ISP) failed to address his specific needs in the area of medication administration, toileting, bathing, and oral hygiene.</p> <p>Findings include:</p> <p>Client #3's records were reviewed on 10/18/12 at 2:58. An ISP dated 7/12/12 included a goal to improve medication skills to "come to the medication administration area...", in the goal area of hygiene skills, "come to the bathroom at the appropriate time to shower...", in the goal area to increase his oral hygiene skills, "come to the bathroom to brush his teeth." There was no evidence in client #3's ISP of objectives to address client #3's specific needs in the area of medication administration, toileting, bathing and oral hygiene.</p> <p>The Residential Director was interviewed on 10/18/12 at 3:30 PM and indicated client #3 required verbal prompts to</p>	W0227	<p>Client #3 ISP has been updated to address all areas of basic needs including: medication administration, toileting, bathing and oral hygiene goals. The House Manager will complete a monthly progress report on these goals to ensure completion and the need for changes based on regression, progression or no change. The QDDP will train staff on how to run the goals and change the goals as necessary to meet the clients needs. The QDDP will assess each new resident during their initial 30 days and have specific goals to address these basic areas of need at their 30 day IPP.</p>	11/09/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/22/2012
NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904		
(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	
	<p>initiate tasks and there were no written objectives to address specific skill needs for client #3 in the area of medication administration, toileting, bathing and oral hygiene.</p> <p>9-3-4(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G586		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/22/2012	
NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904			
(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			
W0249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on record review and interview, the facility failed to implement 1 of 4 sampled clients (client #4) behavior support plan.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and internal incident reports were reviewed on 10/17/12 at 4:05 PM. A report dated 7/2/12 indicated staff #7 had raised her voice to client #4 and pulled her in her wheelchair into the bathroom "during a behavior" and held the bathroom door in an attempt to not let client #4 out.</p> <p>Client #4's record was reviewed on 10/18/12 at 2:16 PM. Client #4's 8/12 behavior intervention plan did not include the use of seclusion behind a closed door, but included the use of redirection to a quiet area.</p>	W0249	<p>All staff have been trained on client #4's behavior plan. Staff were retrained after the time of the incident and have been refreshed again to ensure they are following the BSP as written. Staff were also trained on the agency abuse/neglect policy and Prohibition of Violation of Individual Rights which states that Seclusion is NOT an option and grounds for termination. The House Manager works random shifts to observe compliance with policy/procedure, to oversee the implementation of goals, BSP's, medication administration, and any other program oversight.</p>	11/06/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/22/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904
---	---

(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
	<p>The Residential Director and Residential Coordinator were interviewed on 10/22/12 at 12:23 PM and indicated client #4's plan was not implemented during the incident and client #4's plan included the use of redirection to a quiet area, but did not include the use of placing her in a room with the door shut.</p> <p>9-3-4(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/22/2012
NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904		
(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	
W0268	<p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client.</p> <p>Based on observation, record review and interview, the facility failed for 1 of 4 sampled clients (client #4), and 3 additional clients (clients #5, #7 and #8) to promote dignity by not refraining from discussion about bowel movements of client #8 in the presence of clients #4, #5, and #7.</p> <p>Findings include:</p> <p>Observations were completed in the group home on 10/18/12 from 6:38 AM until 9:00 AM. During the administration of medication at 7:20 AM, staff #2 asked the house manager who was standing in the dining room about client #8's "poop record," and the house manager responded client #8 had a recent bowel movement. Clients #4, #5, and #7 were also in the dining room and within earshot of staff #2's question and the house manager's answer. Client #8 was in her bedroom.</p> <p>The House Manager was interviewed on 10/18/12 at 12:00 PM and indicated she had answered staff #2's question regarding client #8's bowel movement record when asked about her most recent bowel movement.</p>	W0268	<p>On 11/6/12, staff were retrained on treating the clients with respect and dignity at all times. Staff will refrain from discussing personal and private client information in front of other clients. Private client information such as BM records are available for all staff to document on at anytime throughout their shift. Before giving a PRN for constipation, the med passer will check the BM record and/or privately ask other staff if there is a need to discuss such information. The House Manager will observe random shifts to ensure compliance.</p>	11/06/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/22/2012
NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904		
(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	
W0323	<p>9-3-5(a)</p> <p>483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on record review and interview, for 1 of 4 sampled clients (client #1), the facility failed to ensure his hearing was screened annually.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 10/18/12 at 3:50 PM. Client #1's annual physical examination dated 2/1/12 did not include a hearing screening. Client #1's last hearing assessment was 9/3/09.</p> <p>The group home nurse was interviewed on 10/18/12 at 3:00 PM. She indicated client #1's hearing had not been screened since 9/3/09.</p> <p>9-3-6(a)</p>	W0323	<p>Client #1 has hearing screen scheduled for 11/27/12. The QDDP and nurse will assess clients needs on a regular basis to ensure all necessary medical appointments and evaluations have been completed per guidelines. The Periodic Service Review (PSR) is a quality assurance tool to check that necessary paperwork, evaluations, etc are completed in a timely manner. The PSR is completed by the Director of Ancillary Services. Results of the PSR are forwarded to the QDDP and Director of Residential Services.</p>	11/27/2012	