

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G453	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/16/2014
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NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3261 ALMQUIST KOKOMO, IN 46902
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: 12/10, 12/11, 12/12, 12/15, and 12/16/2014.</p> <p>Facility Number: 000967 Provider Number: 15G453 AIMS Number: 100235220</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed December 31, 2014 by Dotty Walton, QIDP.</p>	W000000		
W000125	<p>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.</p> <p>Based on record review and interview, for 1 of 4 sampled clients (client #1) who lived in the group home, the facility failed to ensure client #1 had a legally</p>	W000125	Toensure that client #1 has a legally sanctioned representative to assist himwith his medical and financial needs per his	02/01/2015

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

TITLE

(X6) DATE

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

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	<p>sanctioned representative to assist him with his medical and financial needs per his assessments.</p> <p>Findings include:</p> <p>On 12/12/14 at 2:15pm, a record review for client #1 was conducted. Client #1's 11/5/13 and 9/25/14 "Informed Consent" assessment, 9/25/14 Individual Support Plan (ISP), and 3/25/14 BSP (Behavior Support Plan) indicated client #1 was not independent with his finances and/or medical care. Client #1's Informed Consent assessment, ISP, and BSP indicated the following areas were reviewed: personal finances, housing, personal safety, medical, behavioral, civil rights, and communication. The assessment, ISP, and 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 9/25/14 "Capacity for Independence / Informed Consent" assessment indicated client #1 "is not capable to behave appropriately and safely in the community without supervision." Client #1's record indicated he did not have a legally sanctioned representative and did not have a contact person outside the agency to assist client #1 to understand his rights. Client #1's record indicated he was at risk to be a</p>		<p>assessment, the following correctiveaction(s) will be implemented: 1) TheResidential Director and QIDP will work with existing agencies within ourcommunity and other communities to obtain a valid and qualified advocate forClient #1 to assist him with decision making in regards to medical care,financial obligations, and any other pertinent decisions relating to his careand well-being.</p> <p>a. "Wereany other clients affected by the deficient practice?" No. All other clients residing in thehome have either a legal guardian or a health care representative.</p> <p>b. "Howwill the facility monitor to ensure compliance?" To ensure that all clients residingin the group home setting have appropriate legally sanctioned representatives to assist with medical and financial decisions, the inter-disciplinary teamwill review each client's status with a guardian or health care representativeon an annual basis or as needed if changes in circumstances requires that</p>				

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W000149	<p>victim of abuse. Client #1's record indicated he had a legally sanctioned representative who had died and no current legally sanctioned representative was available.</p> <p>On 12/12/14 at 2:30pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP stated client #1's Informed Consent assessment, ISP, and BSP did indicate he needed an advocate/guardian "to assist him with decision making process" for medications and with his finances. The QIDP indicated client #1 did not have a legally sanctioned representative at this time. The QIDP stated client #1's legally sanctioned representative had "died over a year ago" and client #1 needed a legally sanctioned representative. The QIDP indicated client #1 did not understand his rights, medications, or money and needed an advocate to assist and explain these to client #1.</p> <p>9-3-2(a)</p> <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. Based on observation, record review, and</p>	W000149	theagency assist in obtaining a new or additional representative to assist individual clients.	01/15/2015			

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	<p>interview, for 2 of 2 incidents of sexual exploitation, the facility neglected to implement the agency's policy and procedure to prevent abuse, neglect, and/or mistreatment by neglecting to ensure implementation of the agency's policy and procedure and to ensure staff supervision of clients #1 and #4 based on their identified need.</p> <p>Findings include:</p> <p>On 12/10/14 from 11:55am until 1:35pm, and on 12/11/14 from 5:55am until 8:15am, observations were conducted and clients #1 and #4 shared the same bedroom.</p> <p>On 12/10/14 at 10:20am, a review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 6/1/14 through 12/10/14 was conducted and indicated the following investigation for clients #1 and #4:</p> <p>-A 11/10/14 BDDS report for an incident on 11/9/14 at 7:00am, indicated GHS (Group Home Staff) "had been checking on [clients #1 and #4]. They were awake in their room. [Client #1] was getting ready to leave to go on an outing with someone. [GHS] walked into the room and [client #1] was sitting on the edge of his bed. [Client #1] had one hand that</p>		<p>agency policies and procedures for abuse, neglect, and mistreatment of clients are implemented and executed as written, the following corrective action(s) will be implemented:</p> <p>1) On November 10, 2014, the QIDP and Residential House Manager counseled Client #1 and Client #4 on the importance of privacy and appropriate behavior. Additionally, Client #1 was counseled on understanding the difference between consensual and non-consensual behavior and our policies regarding sexual behavior.</p> <p>2) The inter-disciplinary team (IDT) met to discuss the outcome of the investigation and determined that in order to prevent future acts of inappropriate sexual behavior between Client #1 and Client #4, client #4 needed to be placed in a different bedroom with a different roommate. Another resident in the home was selected to share a room</p>				

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	<p>had his disposable brief pulled down and [client #4] was standing over [client #1] with his hand on [client #1's] penis. [GHS] entered in the room and [client #4] let go and went back over to his side of the room. On 11/10/14 an investigation was done. It was determined that [client #4] had touched [client #1's] penis. [client #1] stated he wanted [client #4] to...Plan to resolve: Staff will be doing every 15 minute room checks anytime they are in the room together...[Client #4] has a history of humping his bed and [client #1] has a history of masturbation and watching adult movies."</p> <p>-A 11/10/14 BDDS report for an incident on 11/8/14 at 5:00pm, indicated GHS (Group Home Staff) "went into [client #1 and #4's] (shared bed) room, they are roommates, on 11/8/14 at 5:00pm to have them come to dinner and [client #1] was laying in his bed and had the top of his undergarment pulled down with the tip of his penis showing and [client #4] was looking at him. When [client #1] saw [the staff] he let go of his undergarment and both of them came to the dinner table with staff."</p> <p>On 12/10/14 at 10:20am, the facility's 11/11/14 "Investigation" into client #1 and #4's incidents was reviewed. The</p>		<p>with Client #1. This resident was selected and agreed upon by IDT due to no prior history of sexual inappropriate behaviors, hiseffective communication skills, and his basic understanding of privacy. Theselected resident was asked for his consent prior to the move and he agreed.The move was completed December 19, 2014.</p> <p>3) Aprivacy screen has been placed in the bedroom to separate the beds and ensureprivacy for Client #1 and his new roommate.</p> <p>4) TheQIDP will revise individual plans for Client #1 and Client #4 to include 15minute checks when either client in his respective room with roommate. Allstaff located at 3261 Almquist Lane (Almquist group home) will be retrained on therevised individual plans for Client #1 and Client #4. A record of training formwill be completed by all staff members when trainings are finalized.</p> <p>5) TheQIDP will create and implement informal goals for both Client #1 and Client #4in</p>				

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	<p>investigation indicated the results were "Throughout this investigation it was found that there was touching done. It was found that the touching was consensual between parties involved in the investigation."</p> <p>On 12/10/14 at 11:00am, a review was completed of the 10/2005 "Bureau of Developmental Disability Services Policy and Guidelines." The BDDS policy and procedure indicated "...Abuse, Neglect, and Mistreatment of Individuals...it is the policy of the company to ensure that individuals are not subjected to physical, verbal, sexual, or psychological abuse by anyone including, but not limited to: facility staff...other individuals, or themselves." The policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs although sources of such support are available and offered and such failure results in physical or psychological harm to the individual." The policy and procedure indicated "...Neglect, includes failure to provide appropriate care, food, medical care, or supervision...."</p> <p>On 12/10/14 at 11:00am, a record review of the facility's undated policy and procedures was conducted. The policy indicated "Abuse, Neglect, Exploitation"</p>		<p>order to educate each client on privacy, inappropriate and appropriate sexual behaviors, and respect of other's right to privacy. All staff located at 3261 Almquist Lane (Almquist group home) will be trained on the implementation and proper execution of the respective informal goals. A record of training form will be completed by all staff members when trainings are finalized.</p> <p>6) To ensure proper monitoring and compliance, the Residential House Manager and QIDP will make frequent unannounced stops to the group home during various shifts. If staff have failed to implement individual plans as directed, the respective staff will be retrained on individual plans and if warranted receive appropriate disciplinary action as outlined in the agency personnel policies and procedures.</p>	

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	<p>neglect was defined as "failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to provide the support necessary to an individual's psychological and social well being. Failure to meet the basic need requirements such as food, shelter, clothing and to provide a safe environment...." The policy indicated failure to implement clients' program plans could also be considered neglect. The policy indicated the facility staff should immediately report allegations of abuse, neglect, and/or mistreatment to the administrator and to BDDS in accordance with State Law.</p> <p>On 12/12/14 at 2:15pm, a record review for client #1 was conducted. Client #1's 11/5/13 and 9/25/14 "Informed Consent" assessment, 9/25/14 Individual Support Plan (ISP), and 3/25/14 BSP (Behavior Support Plan) indicated client #1 was not independent with his finances and/or medical care. Client #1's Informed Consent assessment, ISP, and BSP indicated the following areas were reviewed: personal finances, housing, personal safety, medical, behavioral, civil rights, and communication. The assessment, ISP, and BSP indicated client #1 required twenty-four hour supervision and assistance to understand and to be able to give informed consent in each</p>						

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	<p>area. Client #1's 9/25/14 "Capacity for Independence / Informed Consent" assessment indicated client #1 "is not capable to behave appropriately and safely in the community without supervision." Client #1's record indicated he did not have a legally sanctioned representative and did not have a contact person outside the agency to assist client #1 to understand his rights. Client #1's record indicated he was at risk to be a victim of abuse. Client #1's record indicated he had a legally sanctioned representative who had died but no current legally sanctioned representative was available. Client #1's 3/25/14 BSP indicated client #1 "has some sexually inappropriate behaviors. [Client #1] has a past history of masturbating in front of his roommate. [Client #1] needs guidance from direct support professionals as to healthily ways of doing this and the importance of privacy when he chooses to do this. Direct Support Professionals will make sure to do room checks every 15 minutes when [client #1] and his roommate are in their room together and made (sic) sure the room divider is up."</p> <p>Client #4's record was reviewed on 12/12/14 at 1:55pm. Client #4's 5/21/14 ISP, 5/21/14 BSP, 5/21/14 "Informed Consent" assessment, and 5/21/14</p>			

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	<p>"Capacity for Independence / Informed Consent" assessment, indicated client #4 needed and had three Co-Guardians. Client #4's BSP and ISP indicated he required twenty-four hour supervision by the direct care staff. Client #4's records indicated he was not able to give informed consent. Client #4's records did not indicate a documented behavioral history for sexual exploitation.</p> <p>On 12/12/14 at 2:30pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP stated client #1 and #4's Informed Consent assessments, ISPs, and BSPs did indicate they needed an advocate/guardian "to assist [client #1] with decision making process" for medications and with his finances. The QIDP indicated client #1 did not have a legally sanctioned representative at this time. The QIDP stated client #1's legally sanctioned representative had "died over a year ago" and client #1 needed a legally sanctioned representative. The QIDP indicated clients #1 and #4 did not understand their rights, medications, or money and should have been supervised during the incidents. The QIDP indicated both clients consented to the events on 11/8/14 and 11/9/14. The QIDP indicated clients #1 and #4 continued to be roommates.</p>			

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W000210	<p>9-3-2(a)</p> <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. Based on observation, record review, and interview, for 1 of 1 sampled client (client #2) who was a new admission to the facility, the facility failed to ensure client #2's assessments were completed timely after admission and training needs identified for clients #2's ISP (Individual Support Plan).</p> <p>Findings include:</p> <p>On 12/10/14 from 11:55am until 1:35pm, and on 12/11/14 from 5:55am until 8:15am, observations were conducted. Client #2 wore hearing aids in her right and left ears and wore prescribed eye glasses.</p> <p>Client #2's record was reviewed on 12/12/14 at 1:00pm. Client #2's record indicated she was admitted on 10/28/14 from her family/guardian's home out of state. Client #2's record did not indicate current completed assessments for Vision</p>	W000210	<p>CorrectiveAction(s): Toensure the completion of all necessary and required assessments for Client #2,the following corrective action(s) will be implemented:</p> <p>1) Client#2 moved into the Almquist group home on October 20, 2014. A vision exam forher was conducted on September 12, 2014, which occurred prior to her movinginto the group home. A copy of the exam was obtained on December 30, 2014 and placedin her client records.</p> <p>2) Aninitial hearing exam for Client #2 was conducted on December 22, 2014. Afollow-up visit is scheduled for January 19, 2015. All applicable physicianassessment, notes and records will be place in</p>	01/15/2015

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W000249	<p>and Hearing. Client #2's 10/20/14 ISP indicated she wore prescribed eye glasses and prescribed hearing aids.</p> <p>On 12/12/14 at 2:45pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client #2 wore prescribed eye glasses to see and prescribed hearing aids to hear. The QIDP indicated client #2 was a new admission to the facility. The QIDP indicated client #2 had lived with her family out of state and recently moved to Indiana. The QIDP indicated client #2's family/guardian had indicated the vision and hearing assessments had been completed while client #2 was at her home. The QIDP indicated the facility had not contacted the previous providers for those services to obtain a copy of the current assessment since admission.</p> <p>9-3-4(a)</p> <p>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.</p>		her client records.	
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	<p>Based on observation, interview, and record review, for 1 of 4 sampled client (client #2), the facility failed to use formal and informal opportunities to implement client #2's ISP (Individual Support Plan) and risk plan when opportunities existed.</p> <p>Findings include:</p> <p>On 12/11/14 from 5:55am until 8:15am, observations were conducted at the group home with client #2. At 5:55am, client #2 was assisted by GHS (Group Home Staff) #3 to use her walker to walk throughout the group home. At 6:35am, client #2 with GHS #3 brushed her teeth inside the bathroom with the door open. At 6:45am, client #2 with GHS #1 and GHS #3 filled her plate with Scrambled Eggs, Sausage Links, Hash Brown Potatoes, and Toast in the kitchen. At 6:45am, client #2 with GHS #3 carried her plate with staff assistance and used her walker to go to the dining room table. Client #2's foods were cut up into bite size pieces. At 6:55am, GHS #3 walked away from client #2 sitting at the dining room table eating without staff within eye sight. At 7:00am, GHS #3 walked by client #2 and offered client #2 Ketchup for her Hash Browns and GHS #3 hand over hand assisted client #2 to apply the Ketchup. GHS #3 walked away again</p>	W000249	<p>Toensure proper execution of individual plans for Client #2, the following corrective action(s) will be implemented:</p> <p>1) Allstaff located at 3261 Almquist Lane (Almquist group home) will be retrained onall individual plans for Client #2. Record of training forms will be completedby all staff members when training is finalized. a. "Wereany other clients affected by the deficient practice?" The agency will assume that allresidences in the home have been affected by the deficient practice thatoccurred. Therefore, to prevent future deficient practices, all staff locatedat 3261 Almquist Lane (Almquist group home) will be retrained on all individualplans for all clients residing in the home. b. "Howwill the facility monitor to ensure compliance?" The Qualified Developmental DisabilitiesProfessional (QDDP) and Residential House Manager (RHM) will alternate workingvarious shifts in the home alongside direct support staff. If insufficiencies in level of care by staff are noted by theQDDP and/or RHM, the Director and Vice President of Residential Services willbe immediately notified. Upon notification, the Director and Vice President ofResidential Services will require all staff working in the home to be counseledand re-trained on agency and departmental policies</p>	02/06/2015			

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	<p>leaving client #2 at the dining room table eating her meal without a staff within eye sight supervision. At 7:17am, client #2 was eating at the dining room table without a staff present. At 7:19am, GHS #1 watched the surveyor who was watching client #2 without staff at the dining room table eating. GHS #1 went to client #2 and sat down at the table to supervise her while eating until GHS #2 came into the room. At 7:19am, GHS #1 indicated client #2 was at risk to choke and was to have been within eye sight of the staff while she was at the table dining.</p> <p>On 12/12/14 at 1pm, client #2's record was reviewed. Client #2's 10/20/14 ISP (Individual Support Plan) and 10/20/14 "Dining Plan" indicated client #2 was at risk to choke during eating. Client #2's "Dining Plan" indicated client #2 "has several medical diagnosis that put her at risk for choking and aspirating on her food. [Client #2] is diagnosed with Barrette's Esophagus, GERD, and Esophageal Structures. Barrette's Esophagus causes narrowing of the Esophagus and increases her risk of choking and aspirating on her food. [Client #2] requires supervision from staff every time she eats or is around food...."</p>		and procedures as well as individual client plans. All trainings will be documented on agency Record of Training forms and retained by the Residential Services Coordinator.				

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W000331	<p>On 12/12/14 at 2:30pm, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated client #2 should not have been left without staff supervision at the dining room table around food. The QIDP indicated the facility staff failed to implement client #2's dining plan correctly.</p> <p>9-3-4(a)</p> <p>483.460(c) NURSING SERVICES</p> <p>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 #3), the facility's nursing services failed to provide oversight of client #1 and #3's use of pain medication, failed to develop pain assessments, and failed to develop protocols to manage client #1 and #3's pain.</p> <p>Findings include:</p> <p>1. On 12/10/14 at 4:50pm, GHS (Group Home Staff) #1 asked client #1 to come to the medication room for medication administration. GHS #1 compared client #1's "Gabapentin 300mg (milligrams), take 1 cap by mouth three times daily" for Neuropathic Pain/Peripheral</p>	W000331	<p>Toensure proper pain assessment and the appropriate use of pain medications, thefollowing corrective action(s) will be implemented: 1) TheResidential Nurse has implemented a pain assessment form to assess and monitorclient pain as well monitor PRN pain medication use. <i>Refer to Appendix A to see the pain assessment form currently beingused by staff.</i> The pain assessmentform will be used in the following manner: prior to administering the PRN forpain, all PRNs will be reviewed and administered if available. Once the PRN isadministered it will be recorded in theMAR and the staff will then complete the pain assessment form. The</p>	02/01/2015

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	<p>Neuropathy to client #1's 12/2014 MAR (Medication Administration Record). GHS #1 dispensed client #1's medications into a medication cup and handed the medications to client #1. Client #1 consumed the medication. GHS #1 did not ask regarding client #1's pain.</p> <p>Client #1's record was reviewed on 12/12/14 at 2:15pm. Client #1's 11/16/14, 8/9/14, and 5/29/14 nursing reviews did not address client #1's pain and client #1's use of pain medication. Client #1's diagnoses included, but were not limited to: Cerebral Palsy, Muscle Weakness, and Chronic Pain. Client #1's 11/2014 "Physician's Order" indicated "Gabapentin 300mg (milligrams), take 1 cap by mouth three times daily" for Neuropathic Pain/Peripheral Neuropathy, Acetaminophen 325mg, take 2 tablets by mouth every 4 hours as needed" for pain, and "Tramadol 50mg, take 1 tablet by mouth every 4 hours max. (maximum) of 5 tablets per day as needed" for chronic pain. Client #1's record did not include a plan for client #1's pain.</p> <p>On 12/12/14 at 11:00am, an interview with the RN (Registered Nurse) was conducted. The RN indicated no plan had been developed and no assessment had been completed to manage client #1's</p>		<p>completed pain assessment form will be placed in the designated folder within the respective client's records. 2) All staff located at 3261 Almquist Lane (Almquist group home) were trained on the new pain assessment procedure on January 9, 2014. Completed record of training forms were obtained from all staff. 3) To ensure proper monitoring and compliance, the Residential Nurse will review all MARs on a weekly basis. If per the MAR, a PRN has been administered, the Residential Nurse will verify that a pain assessment form has been completed. If staff have failed to complete pain assessment forms as previously trained, the respective staff will be retrained on the pain assessment process and if warranted receive appropriate disciplinary action as outlined in the agency personnel policies and procedures. <i>a. "prior to administering the PRN for pain, all PRNs will be reviewed and administered if available. Could the facility please explain what this means?"</i> If a PRN of pain medication is needed, the direct care staff will review the MAR to ensure that the client is approved for PRN use of the specified medication, to verify the</p>	

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	<p>pain. The RN stated client #1 was "receiving routine" pain medications every day. The RN indicated client #1 had used his as needed medications when he needed the medications.</p> <p>2. On 12/11/14 at 7:50am, GHS (Group Home Staff) #1 asked client #3 to come to the medication room for medication administration. GHS #1 compared client #3's "Voltaren 1% Gel, apply 4 grams to right knee up to four times a day" for pain to client #3's 12/2014 MAR (Medication Administration Record). GHS #1 dispensed client #3's Voltaren gel and applied the gel to client #3's right knee. GHS #1 did not ask regarding client #3's pain.</p> <p>On 12/12/14 at 1:30pm, client #3's record was reviewed. Client #3's 11/16/14, 8/9/14, 5/29/14, and 2/21/14 nursing reviews did not address client #3's pain and client #3's use of pain medication. Client #1's diagnoses included, but were not limited to: Arthritis. Client #3's 11/2014 "Physician's Order" indicated "Voltaren 1% Gel, apply 4 grams to right knee up to four times a day" for pain and "Meloxicam 15mg, take 1/2 tablet by mouth" twice a day for pain changed on 12/6/14 to "as needed for joint pain once daily." Client #3's record did not include a plan for client #3's pain.</p>		<p>allowabledosage along with any other instructions, and to ensure proper administrationof the medication for its indication.</p> <p>b. "Isthe nurse contacted prior to administering the PRN?"</p> <p>If the PRN is for routine use (i.e.headache, common cold, or cough), the nurse is not notified. The direct carestaff are trained to follow the process listed above in which they are toreview the MAR prior to administering the medication. If however, if there is aPRN medication that is to be used prior to a medical procedure or forbehavioral needs, then either the nurse or QIDP is contacted prior toadministration for approval.</p>	

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W000369	<p>On 12/12/14 at 11:00am, an interview with the RN (Registered Nurse) was conducted. The RN indicated no plan had been developed and no assessment had been completed to manage client #3's pain. The RN stated client #3 was "receiving routine" pain medications every day. The RN indicated client #3 had as needed medications when she needed the medications for pain.</p> <p>9-3-6(a)</p> <p>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.</p> <p>Based on observation, record review, and interview, for 2 of 33 medications administered during the morning medication administration (clients #6 and #7), the facility failed to ensure client #6 and #7's medications were given without error.</p> <p>Findings include:</p> <p>1. On 12/11/14 at 6:15am, GHS (Group Home Staff) #1 asked client #7 to come to the medication room for medication administration. GHS #1 compared client</p>	W000369	<p>Toensure that all medications are administered as prescribed by physicians' orders and without error, the following corrective action(s) will beimplemented: 1) Allstaff located at the location of 3261 Almquist Lane (Almquist group home) will receive re-training on the agency medication administration policy Completed Record of Trainings will be obtained and submitted upon completion of training. <i>Referto Appendix B for Record of Training forms to be used.</i> It is the intent that this training will prevent future medication errors for the</p>	02/06/2015

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	<p>#7's "Glycopyrrol 1mg (milligram) tab (tablet) take 1 tablet by mouth twice a day 1HR (one hour) before meals" to decrease stomach pain (antispasmodic) to client #7's 12/2014 MAR (Medication Administration Record). GHS #1 handed client #7 the Glycopyrrol medication in a medication cup, and client #7 consumed the medication. No food or a meal was provided. Client #7 walked out of the medication room and to the kitchen. At 6:23am, client #7 consumed his first bite of food at the morning meal. At 7:06am, client #7's 12/2014 MAR and 11/1/14 physician orders were reviewed and indicated "Glycopyrrol 1mg (milligram) tab (tablet) take 1 tablet by mouth twice a day 1HR (one hour) before meals" to decrease stomach pain and antispasmodic.</p> <p>2. On 12/11/14 at 7:26am, GHS #1 asked client #6 to come to the medication room for medication administration. GHS #1 administered client #6's oral medications and suggested to client #6 that he lay down to have his ear drops administered. GHS #1 selected and compared to the 12/2014 MAR client #6's "Ofloxacin 0.3% ear drops, administer 5 drops 3 times a day into the L (left) ear" for ear wax. Both GHS #1 and client #6 went to client #6's bedroom and client #6 laid down on his bed. GHS</p>		<p>clients affected as well as all other clients residing in the home. <i>How did the facility monitor the particular staff that made the med error the next time that the staff person passed meds?"</i></p> <p>1. The Residential Nurse retrained the particular staff member on proper medication administration. The staff member has not had any medication errors since being re-trained. To prevent future medication errors, the Residential Nurse will re-train all other staff located at 3261 Almquist Lane (Almquist group home) on the agency medication administration policy. To ensure staff competency to successfully administer medications as directed per physician orders, the Residential Nurse will observe a medication pass by the staff member.</p> <p><i>2. "How will the facility consistently monitor the med pass to ensure competency and compliance?"</i></p> <p>All Residential Nurses will be required to develop systems in which they a) conduct weekly</p>				

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	<p>#1 opened the medication bottle and no medication was available for use. GHS #1 returned to the medication room, attempted to locate another bottle of medication, and none was available for use. GHS #1 asked another staff if client #6 had additional ear drop medication and the remaining staff indicated they did not know. GHS #1 researched information regarding the medication and indicated the medication had not been refilled on the routine medication dispensing from the pharmacy on the first of the month. On the previous day the drops had not administered because it had not been reordered and no medication was available for client #6 to receive. GHS #1 indicated no documentation was available for review that the nurse was notified of the medication shortage. At 7:30am, client #6's 12/2014 MAR and 11/2014 "Physician's Order" both indicated "Ofloxacin 0.3% ear drops, administer 5 drops 3 times a day into the L (left) ear" for ear wax.</p> <p>On 12/12/14 at 11:00am, an interview with the Agency RN (Registered Nurse) was conducted. The RN indicated she had not been notified of client #6's medication not being available for administration and should have been.</p> <p>The RN indicated client #6 and #7's</p>		<p>reviews of all medication records for all clients residing in the homeb) observe staff on a routinely basis to ensure that all medications areadministered according to physician's orders and agency policy. In the event of a medication error, theResidential Nurse will immediately review all medication records for allclients residing in the home, not just those that are affected, to ensure thatno other medication errors have occurred, that staff fully comprehend andunderstand directives for medication administration as stated on the MAR(medication administration record), and that medications are being administeredaccording to physician's orders and agency policy.</p>		

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W000436	<p>medications should have been administered according to their Physician's orders. The RN indicated the facility staff should administer medications according to Core A/Core B medication administration training. The RN indicated client #7's medication was given in error when the medication was not given one hour before food was provided.</p> <p>On 12/10/14 at 1:00pm, a record review of the facility's 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.</p> <p>9-3-6(a)</p> <p>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.</p> <p>Based on observation, record review, and interview, for 1 of 3 sampled clients (clients #4) who wore eye glasses, the facility failed to teach and encourage client #4 to wear his prescribed eye</p>	W000436	<p>Toensure proper execution of the vision plan for Client #4, the followingcorrective action(s) will be implemented:</p> <p>1) Allstaff located at the location of 3261 Almquist Lane (Almquist</p>	02/01/2015			

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	<p>glasses.</p> <p>Findings include:</p> <p>On 12/10/14 from 11:55am until 1:35pm, and on 12/11/14 from 5:55am until 8:15am, observations were conducted and client #4 did not wear his prescribed eye glasses. During both observation periods client #4 completed dining, walked throughout the group home, walked throughout the workshop, completed medication administration, and watched television. Client #4 was not encouraged to wear his prescribed eyeglasses.</p> <p>Client #4's record was reviewed on 12/12/14 at 1:55pm. Client #4's 12/4/14 visual examination indicated client #4 wore prescribed eye glasses to see. Client #4's 5/21/14 ISP (Individual Support Plan) did not indicate an objective to teach and wear his prescribed eye glasses.</p> <p>On 12/12/14 at 2:45pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client #4 wore prescribed eye glasses to see. The QIDP indicated staff should use formal and informal opportunities to teach and encourage client #4 to wear his</p>		<p>group home) will receive training on vision plan for Client #4. Completed Record of Trainings will be obtained and submitted upon completion of training.</p> <p>a. "Were any other clients affected by the deficient practice?"</p> <p>The agency will assume that all residences in the home have been affected by the deficient practice that occurred. Therefore, to prevent future deficient practices, all staff located at 3261 Almquist Lane (Almquist group home) will be retrained on all individual plans for all clients residing in the home.</p> <p>b. "How will the facility monitor to ensure compliance?"</p> <p>The Qualified Developmental Disabilities Professional (QDDP) and Residential House Manager (RHM) will alternate working various shifts in the home alongside direct support staff. If insufficiencies in level of care by staff are noted by the QDDP and/or RHM, the Director and Vice President of Residential Services will be</p>				

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W000455	<p>prescribed eye glasses.</p> <p>9-3-7(a)</p> <p>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.</p> <p>Findings include:</p> <p>On 12/11/14 from 5:55am until 8:15am, observations were conducted at the group home with clients #1, #2, #3, #4, #5, #6,</p>	W000455	<p>immediately notified. Upon notification, the Director and Vice President of Residential Services will require all staff working in the home to be counseled and re-trained on agency and departmental policies and procedures as well as individual client plans. All trainings will be documented on agency Record of Training forms and retained by the Residential Services Coordinator.</p> <p>To ensure hygiene and cleanliness in regards to proper hand-washing techniques, the following corrective action(s) will be implemented: 1) All staff located at the location of 3261 Almquist Lane (Almquist group home) will receive re-training on the agency hand-washing policy and procedures. Completed Record of Trainings will be obtained and submitted upon completion of training. <i>Refer to Appendix C for Record of Training forms to be used.</i> a. <i>"The question from the previous addendum was</i></p>	02/06/2015

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	<p>#7, and #8. From 5:55am until 7:06am, clients #1, #2, #3, #4, #5, #6, #7, and #8 read the newspaper, swept the floor, brushed/combed their hair, sorted laundry, cooked in the kitchen with Group Home Staff (GHS) #1, #2, and #3, client #6 collected trash from the trash cans in the rooms, client #6 took out the trash, petted the facility animals, clients #2 and #3 wrote on paper, and no handwashing was observed taught or encouraged. From 5:55am until 7:06am, clients #1, #2, #3, #4, #5, #6, #7, and #8 fixed their individual servings of breakfast in the kitchen with the group home staff without washing their hands. Clients #1, #2, #3, #4, #5, #6, #7, and #8 stirred eggs in a skillet, made toast and handled bread, sat down at the dining room table to eat, and no handwashing was taught or encouraged. At 8:00am, clients #1, #2, #3, #4, #5, #6, #7, and #8 all indicated they had not washed their hands before eating breakfast. At 8:00am, clients #3 and #6 stated together "No, I didn't wash them" before cooking and consuming the breakfast meal.</p> <p>On 12/11/14 at 9:00am the facility's undated policy and procedure for "Handwashing" and infection control was reviewed and indicated "All persons who are served...are to wash hands before and after providing personal care to an</p>		<p>not addressed?" There was no question for this tagnumber in the previous addendum. The previous addendum letter had W436 listedas the last tag to address.</p>				

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W009999	<p>individual and before preparing, serving, or eating food."</p> <p>On 12/12/14 at 2:30pm, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 should have washed their hands before cooking and/or eating breakfast. The QIDP indicated the staff should have prompted the clients to wash their hands. The QIDP indicated the facility's handwashing policy and procedure was not followed.</p> <p>9-3-7(a)</p> <p>STATE FINDINGS:</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rules were not met.</p> <p>1. 460 IAC 9-3-2(c)(3) Resident protections</p> <p>(c) The residential provider shall demonstrate that its employment practices assure that no staff person would be employed where there is:</p>	W009999	<p>Toensure that all required documentation is placed in an employee's personnelfile, the following corrective action(s) will be implemented:</p> <p>1) Uponhire of a new employee, the Residential Services Coordinator will collaboratewith the agency Human Resources staff to ensure completion of proper filedocumentation of required information for employees.</p>	01/15/2015			

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	<p>(3) conviction of a crime substantially related to a dependent population or any violent crime. The provider shall obtain, as a minimum, a bureau of motor vehicles record, a criminal history check as authorized in IC 5-2-5-5, and three (3) references. Mere verification of employment dates by previous employers shall not constitute a reference in compliance with this section.</p> <p>THIS STATE RULE WAS NOT MET AS EVIDENCED BY:</p> <p>Based on record review and interview, for 1 of 3 personnel files reviewed (Group Home Staff (GHS) #1), the facility failed to complete a bureau of motor vehicles (BMV) record screening.</p> <p>Findings include:</p> <p>On 12/12/14 at 9:30am, the facility staff personnel records were reviewed for GHS #1 and indicated the following: -GHS #1 was hired on 3/17/14. GHS #1's record did not indicate a completed BMV screening. GHS #1's record indicated he had recently moved to Indiana from the state of North Carolina.</p> <p>On 12/12/14 at 9:45am, the QIDP (Qualified Intellectual Disabilities Professional) indicated no further</p>		<p>Once verifying the completion of the required documentation, the Residential Services Coordinator will complete a "New Employee Checklist" for every new employee within the department and maintain the records in a designated location within the department. <i>Refer to Appendix D for New Employee Checklist forms to be used.</i></p>		

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	<p>information was available for review.</p> <p>On 12/15/14 at 2pm, the QIDP (Qualified Intellectual Disabilities Professional) provided an additional BMV check for GHS #1 completed on 12/15/14 for the State of Indiana.</p> <p>9-3-2(c)(3)</p> <p>(2) 460 IAC 9-3-3 Facility Staffing</p> <p>(e) Prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin (TB) test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. If the skin test result is significant (ten (10) millimeters or more), then a chest film shall be done with other physical and laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the physician.</p> <p>THIS STATE RULE WAS NOT MET AS EVIDENCED BY:</p> <p>Based on record review and interview for</p>						

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	<p>3 of 3 personnel records reviewed (Group Home Staff (GHS) #1, #2, and #3), the facility failed to obtain yearly PPD and/or a chest x-ray for employed staff #1, #2, and #3.</p> <p>Findings include:</p> <p>On 12/12/14 at 9:30am, the facility staff personnel records were reviewed for GHS #1, GHS #2, GHS #3 and indicated the following:</p> <p>-GHS #1 was hired on 3/17/14. GHS #1's record did not indicate a current chest x-ray and/or Mantoux test to ensure the staff person was free of communicable disease.</p> <p>-GHS #2 was hired on 9/20/14. GHS #2's record did not indicate a current chest x-ray and/or Mantoux test to ensure the staff person was free of communicable disease.</p> <p>-GHS #3 was hired on 3/17/14. GHS #3's record did not indicate a current chest x-ray and/or Mantoux test to ensure the staff person was free of communicable disease.</p> <p>On 12/12/14 at 9:45am, the QIDP (Qualified Intellectual Disabilities Professional) indicated no further</p>						

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	<p>information was available for review.</p> <p>On 12/15/14 at 9:50am, and on 12/15/14 at 2pm, the QIDP (Qualified Intellectual Disabilities Professional) provided TB testing for GHS #1 read on 4/9/14 0mm (millimeters), for GHS #2 read on 10/27/14 0mm, and for GHS #3 read on 11/26/14 0mm.</p> <p>On 12/16/14 at 11:20am, the facility's 4/2006 "Personnel Policies and Procedures: Health Regulations" indicated "...2. All Bona Vista Programs staff members must have a Mantoux (TB) test on file with the agency. All employees...are required to have a Mantoux test before the first day of direct care services and annually thereafter."</p> <p>Interview with the Vice President of Residential Services (VPRS) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 12/16/14 at 11:20am. The VP and QIDP both indicated staff should have a completed TB test read before the first day of working with clients at the group home.</p> <p>9-3-3(e)</p>				