STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	15G789		08/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONA VISTA PROGRAMS INC	3770 W 80 N KOKOMO, IN 46901

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W 0000 Bldg. 00	This visit was for the investigation of complaint #IN00180739. Complaint #IN00180739: SUBSTANTIATED, Federal and State deficiencies related to the allegations were cited at W122, W149, W249, and W289. Unrelated deficiencies cited. Dates of Survey: 8/25, 8/26, 8/27, and 8/28/2015. Provider Number: 15G789 AIM Number: 201012970 Facility Number: 012485 The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review of this report completed by #09182 on 9/03/2015.	W 0000	**Toensure that client programs are implemented as written, the followingcorrective actions will be implemented:** 1) AllQualified Intellectual Disabilities Professionals (QIDP) within the ResidentialServices Department will office out of the same building as the ResidentialDirector and Residential Vice President to provide continuous and more thoroughadministrative oversight in their work. Additionally, the QIDP will spend adesignated amount of time each day in their assigned group home to provideone-on-one interaction with the clients, to ensure that designated plans areeffective and meet client needs, and to help administrative staff determine howwe may better meet individual client needs. 2) TheQIDP will meet with the Residential Director on a weekly basis to providestatus updates on client goals,	

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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			individual plans, etc. and to provide theResidential Director the opportunity to review goals and plans and to makenecessary suggestions, changes, or revisions. Upon any changes, the QIDP will seekapproval from the Inter-Disciplinary Team. Once approved, the QIDP will then implementthe revised plans and provide immediate training to all direct care staffworking in the home. 3) TheResidential House Manager will review documentation of client programs on aweekly basis to ensure that programs and goals are being implemented aswritten. In the event that program goals and plans are not being implemented aswritten, the Residential House Manager will notify the QIDP who will in turn providere-training for all staff working in the home.	
W 0122 Bldg. 00	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview, and record review, the facility failed to ensure	W 0122	**Toensure that individual plans for Client A are written to best**	09/27/2015

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	client A was supervised by the staff based on her known behavior needs and the facility failed to meet the Condition of Participation: Client Protections for 3 of 3 sampled clients (clients A, B, and C) and 5 additional clients (clients D, E, F, G, and H). The facility failed to implement their policy and procedures to report, to investigate, and to protect clients A, B, C, D, E, F, G, and H from the potential of abuse, neglect, and/or mistreatment after allegations of staff mistreatment by client H. Findings include: Please refer to W149. The facility neglected for 1 of 19 incidents (for client A) and 1 of 1 unreported allegation reviewed for 8 of 8 clients (clients A, B, C, D, E, F, G, and H), the facility neglected to ensure client A was supervised by the facility staff based on her identified known behavioral needs and neglected to implement client A's ISP (Individual Support Plan) and BSP (Behavior Support Plan). The facility neglected to implement the agency's policy and procedure to immediately report allegations of staff to client abuse, neglect, and/or mistreatment to the administrator and to BDDS (Bureau of Developmental Disabilities Services) in accordance with State Law, and to		**fit her needs andto ensure that all individual plans for Client A are being followed as written,the following corrective action(s) will be implemented:** 1) TheDiagnostic and Evaluation forms (D&E) for Client A will be reviewed andrevisions to her Behavior Support Plans (BSP) will be completed to reflect pastinformation and present information needed for continuity of care. The revisedBSP will include historical information, additional targeted behaviors, CIPintervention, routine body checks, and a level system that will dictateinstructions for restrictions and supervision for suicide ideations andattempts. Additionally, the QIDP willcreate a suicide ideation/attempt risk plan with step by step instructions ofwhich staff members to contact when Client A engages in this type of behavior. Alldirect care staff working in the home will be promptly trained on any revisionsor additions to Client A's individual plans. Record of Training forms willcompleted once all trainings are finalized. 2) Allstaff located at 3770 North 80 West (Sycamore Group home) will be retrained onthe agency accident/injury process and incident reporting as well as changes tothe internal routing system for the above mentioned processes to ensureevaluation of all accident/injury and incident reports in a more timely	

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	complete thorough investigations for clients A, B, C, D, E, F, G, and H. Please refer to W153. The facility failed for 1 of 1 unreported allegation reviewed for 8 of 8 clients (clients A, B, C, D, E, F, G, and H), the facility failed to immediately report to the facility's administrator and to BDDS (Bureau of Developmental Disabilities Services) per 460 IAC 9-3-1(b)(5) and to Adult Protective Services (APS) per IC 12-10-3 regarding an allegation of staff to client abuse, neglect, and/or mistreatment for clients A, B, C, D, E, F, G, and H. Please refer to W154. The facility failed for 1 of 1 unreported allegation reviewed for 8 of 8 clients (clients A, B, C, D, E, F, G, and H), the facility failed to thoroughly investigate an allegation of staff to client abuse, neglect, and/or mistreatment for clients A, B, C, D, E, F, G, and H. This federal tag relates to complaint #IN00180739. 9-3-2(a)		manner.Record of training forms will be completed once trainings are finalized. *Refer to Appendix A and B for Record ofTraining forms to be used* **Toensure that established agency policies and procedures for abuse, neglect, andincident reporting are being implemented and executed as written, the followingcorrective action(s) will be implemented:** 1) Allstaff located at 3770 North 80 West (Sycamore Group home) will be retrained onthe agency accident/injury process and incident reporting as well as changes tothe internal routing system for the above mentioned processes to ensureevaluation of all accident/injury and incident reports in a more timely manner.Record of training forms will be completed once trainings are finalized. *Refer to Appendix A and B for Record ofTraining forms to be used* 2) AllResidential House Managers (RHM) and Qualified Intellectual DisabilitiesProfessional (QIDP) within the Residential Services Department will beretrained on BDDS reportable guidelines, how to file a BDDS report, andevaluations for all accident/injury reports to ensure a higher level ofmonitoring with all incidents. Record of training forms will be completed asall trainings are finalized. *Refer toAppendix C for Record of Training form to be used*.	

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			Toensure that established agency policies and procedures for investigations arebeing implemented and executed as written, the following corrective action(s)will be implemented: 1) Allinvestigations will be conducted in the manner outlined on the ResidentialServices Investigation Process. *Refer toAppendix D for process outline.* To ensure that all investigations areconducted in a uniform and consistent manner, all Residential House Managers,Qualified Development Disability Professionals, Nurses, the Director, and theResidential Services Coordinator will be trained on the newly establishedinvestigation process outline. *Refer toAppendix E for Record of Training form to be used in documenting training*.	
W 0149 Bldg. 00	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 interview, for 1 of 19 incidents (for client A) and 1 of 1 unreported allegation reviewed for 8 of 8 clients (clients A, B, C, D, E, F, G, and H), the facility neglected to ensure client A was supervised by the facility staff based on her identified known behavioral needs and neglected to implement client A's ISP	W 0149	**Toensure that individual plans for Client A are written to best fit her needs andto ensure that all individual plans for Client A are being followed as written,the following corrective action(s) will be implemented:** 1) TheDiagnostic and Evaluation forms (D&E) for Client A will be reviewed andrevisions to her Behavior Support Plans (BSP) will	09/27/2015

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	(Individual Support Plan) and BSP (Behavior Support Plan). The facility neglected to implement the agency's policy and procedure to immediately report allegations of staff to client abuse, neglect, and/or mistreatment to the administrator and to BDDS (Bureau of Developmental Disabilities Services) in accordance with State Law, to complete thorough investigations, and to complete effective corrective action for clients A, B, C, D, E, F, G, and H. Findings include: 1. On 8/25/15 at 8:45am, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and included the following suicide attempt incident for client A: -An 8/20/15 BDDS report for an incident on 8/20/15 at 6:15am, indicated the Group Home Staff (GHS) #1 "went into [client A's] room at 6:15am to wake her up and found her in her bed with a shoestring tied tight around her neck. [Client A] was alert and breathing, but staff immediately cut off the string off her neck. [Client A] reported to staff I was trying to kill myself and was crying. Staff contacted the On Call and was instructed to start safety checks and		be completed to reflect pastinformation and present information needed for continuity of care. The revisedBSP will include historical information, additional targeted behaviors, CIPintervention, routine body checks, and a level system that will dictateinstructions for restrictions and supervision. Additionally, the QIDP will create a suicideideation/attempt risk plan with step by step instructions of which staffmembers to contact when Client A engages in this type of behavior. All directcare staff working in the home will be promptly trained on any revisions oradditions to Client A's individual plans. Record of Training forms willcompleted once all trainings are finalized. ***b.*** **Toensure that established agency policies and procedures for incident reportingand investigations are being implemented and executed as written, the followingcorrective action(s) will be implemented:** 1) Allstaff located at 3770 North 80 West (Sycamore Group home) will be retrained onthe agency accident/injury process and incident reporting as well as changes tothe internal routing system for the above mentioned processes to ensureevaluation of all accident/injury and incident reports in a more timely manner.Record of training forms will be completed once trainings are finalized. *Refer to Appendix A*	

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	remove all items [client A] could use to harm herself. Staff kept [client A] within line of sight and removed all strings, cords, and small items. Staff found three (3) light red marks around [client A's] neck." The report indicated client A's psychiatrist was contacted and recommended to take client A to the local Emergency Room (ER). The report indicated client A "once at the emergency room [client A] reported that she was still having suicidal thoughts and said I heard the devil say I was going to die." The report indicated client A "has a long history of engaging in these behaviors and they sometimes occur with no warning. It has been over 12 months since [client A] has engaged in any suicidal behavior...The psychiatrist chose to discontinue [client A's] Clozapine (for behaviors) on 7/28/15 due to [client A's] primary care physician's concern of anemia from [client A's] lab result." Client A's record was reviewed on 8/25/15 at 11:05am. Client A's 4/8/15 ISP and 4/2015 BSP both indicated her diagnoses included. but were not limited to: "Schizoaffective Disorder, Borderline Personality Disorder." Client A's ISP and BSP indicated targeted behaviors of "Self Injurious behavior/PICA (consuming inedible items), Suicidal Ideation/Attempt, Elopement, Self		*and B for Record ofTraining forms to be used.* 2) AllResidential House Managers (RHM) and Qualified Intellectual DisabilitiesProfessionals (QIDP) within the Residential Services Department will be retrainedon BDDS reportable guidelines, how to file a BDDS report, and evaluations forall accident/injury reports to ensure a higher level of monitoring with allincidents. Record of training forms will be completed as all trainings arefinalized. *Refer to Appendix C for Recordof Training form to be used*. 3) Allinvestigations will be conducted in the manner outlined on the ResidentialServices Investigation Process. *Refer toAppendix D for process outline.* To ensure that all investigations areconducted in a uniform and consistent manner, all Residential House Managers,Qualified Development Disability Professionals, Nurses, the Director, and theResidential Services Coordinator will be trained on the newly established investigationprocess outline. *Refer to Appendix E forRecord of Training form to be used in documenting training*.	

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	Deprecating Speech, and Giving Items Away." -Client A's ISP and BSP both indicated staff were to provide twenty-four hour supervision. Client A's BSP indicated "is an emancipated adult...has a long history of numerous placements due to elopement and self injurious behavior...has a history of various types of abuse including sexual abuse by her foster father resulting in pregnancy. She has a history of suicidal ideation and attempts. In the past [client A] attempted to jump out of a moving vehicle during times of depression. She climbed a fence and attempted to jump off a bridge in order to drown herself several years ago...Intervention...[Client A] should not have in her possession non edible items that she could swallow during periods of depression and decompensation. She should also not have access to strings, ties, ropes, cords, sharp objects, hazardous chemicals or objects that she could break during episodes of suicidal talk or decompensation...[Client A's] threats of suicide are often a result of impulsive actions or attention seeking. If she is attempting to seek attention...Any objects she could harm herself with will be removed and staff will provide constant supervision...." Client A's plans did not define who authorized the			

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	removal/return of client A's items based on her behaviors, room sweeps monitoring, staff supervision levels when client A displayed self injurious behaviors, and the restricted techniques employed. Client A's plans did not define the length of time for client A's "depression and decompensation" periods before returning items and changing staff supervision levels. During observation on 8/25/15 from 6:40am until 8:10am at the group home, client A was not present. From 6:40am until 8:10am, client A's shared bedroom was observed to have two of two (2 of 2) windows each with blinds with four cords each hanging from the two window coverings. At 7:00am, GHS #1 indicated client A's two window blinds each had four (4) cords hanging from the blinds. GHS #1 stated client A was in the hospital "currently" after she attempted suicide on 8/20/15. GHS #1 stated client A was "upset and crying" the day before the incident. GHS #1 stated she was on duty at the group home on 8/20/15, discovered client A with the shoe strings tied "tight" around her neck, and she had to "cut" the shoe strings from client A's neck with scissors. GHS #1 stated client A had experienced increased behaviors of crying and "wanting to die" since "early" July, 2015. GHS #1 indicated client A's			

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	psychiatrist had been decreasing and changing her medications since early 7/2015. Confidential Interview (CI) #1 stated client A was "crying, upset, felt bad about herself, talked to staff, then went to bed" the evening before 8/20/15. CI #1 stated "then she tried to kill herself in the morning." On 8/27/15 at 12:50pm, an interview with the Director of Residential Services (DRS) was conducted. The DRS stated client A's psychiatrist had been changing client A's psychiatric medications beginning in "around June/July, 2015." The DRS indicated the change in psychiatric medications was due to client A's lab values and Anemia caused by the medications. The DRS stated "We saw increased behaviors" from client A regarding self deprovating talk, giving her items away, and thoughts of suicide. The DRS provided client A's behavior reports which indicated client A had experienced increased crying and behaviors in 7/2015 and 8/2015. The DRS stated client A was crying and "talked of self deprovation" on 8/2/15. The DRS stated "We never thought about the blinds in her room having cords" and indicated the cords will be removed. The DRS indicated neglect was the failure to			

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	provide sufficient staff supervision based on identified behaviors. The DRS indicated client A's suicidal behaviors were known to the facility, her medication decreases were known to the facility, and the attempt occurred at the facility. The DRS indicated client A accessed her shoe strings, removed the strings from her shoes, and attempted to hang herself on 8/20/15. 2. On 8/25/15 at 8:45am, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and did not include the following allegation of abuse, neglect, and/or mistreatment for clients A, B, C, D, E, F, G, and H: -An 8/10/15 "Residential Services Investigation" indicated "Summary of Events: Staff members brought it to the attention of the DRS that staff member [name of GHS #3] was being very difficult to work with. [The staff names] stated that [GHS #3] was being very intimidating towards other staff members." The investigation did not document client B's allegation of staff to client abuse, neglect, and/or mistreatment. -The 8/10/15 investigation included an interview with client B which indicated			

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	"Are there any staff that work in your home that are bullies or intimidating? Yeah, Well No...Are there any staff that have cussed in front of you? Yes. [GHS #4] told me to get my --- up. Do you like all your staff? [GHS #3] tells me that I'm the baddest one of all. She tells me to be quiet. [GHS #5] tells me that I stink when I have accidents, that he is tired of me." The 8/10/15 investigation was not reported to the administrator and to BDDS according to staff law and was not thorough in that the investigation did not indicate corrective action recommendations as a result of the investigation. The investigation did not include investigating client B's allegations regarding GHS #3, GHS #4, and GHS #5. On 8/27/15 at 12:50pm, an interview with the DRS, the QIDP (Qualified Intellectual Disabilities Professional), and the Vice President of Residential Services (VPRS) was conducted. The DRS, QIDP, and the VPRS indicated the agency investigated a staff reported event of staff bullying on 8/10/15. The DRS indicated the facility followed the BDDS policy and procedure for allegations of abuse, neglect, and/or mistreatment. The DRS indicated the facility did not report			

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	to the administrator and/or to BDDS in accordance with State Law and did not investigate client B's allegation of staff mistreatment. On 8/25/15 at 8:45am, 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...." On 8/25/15 at 8:45am, a record review of the facility's undated policy and procedures for Abuse, Neglect, Exploitation indicated "Abuse, Neglect, Exploitation" neglect was defined as "failure to provide goods and/or services			

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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
	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. This federal tag relates to complaint #IN00180739. 9-3-2(a)			
W 0153 Bldg. 00	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview, for 1 of 1 unreported allegation reviewed for 8 of 8 clients (clients A, B, C, D, E, F, G, and H), the facility failed to immediately report to the facility's administrator and to BDDS (Bureau of	W 0153	***a.*** **Toensure that all established federal and agency policies and procedures forabuse, neglect, and incident reporting are being implemented and executed aswritten, the following**	09/27/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G789	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/28/2015
NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 3770 W 80 N KOKOMO, IN 46901	

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	Developmental Disabilities Services) per 460 IAC 9-3-1(b)(5) and to Adult Protective Services (APS) per IC 12-10-3 regarding an allegation of staff to client abuse, neglect, and/or mistreatment for clients A, B, C, D, E, F, G, and H. Findings include: On 8/25/15 at 8:45am, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and did not include the following allegation of abuse, neglect, and/or mistreatment for clients A, B, C, D, E, F, G, and H: -An 8/10/15 "Residential Services Investigation" indicated "Summary of Events: Staff members brought it to the attention of the DRS (Director of Residential Services) that staff member [name of GHS (Group Home Staff) #3] was being very difficult to work with. [The staff names] stated that [GHS #3] was being very intimidating towards other staff members." The investigation did not document client B's allegation of staff to client abuse, neglect, and/or mistreatment. -The 8/10/15 investigation included an interview with client B which indicated "Are ther9e any staff that work in your		**corrective action(s) will be implemented:** 1) Allstaff located at 3770 North 80 West (Sycamore Group home) will be retrained onthe agency accident/injury process and incident reporting as well as changes tothe internal routing system for the above mentioned processes to ensureevaluation of all accident/injury and incident reports in a more timely manner.Record of training forms will be completed once trainings are finalized. *Refer to Appendix A and B for Record ofTraining forms to be used* 2) AllResidential House Managers (RHM) and Qualified Intellectual DisabilitiesProfessional (QIDP) within the Residential Services Department will be retrainedon BDDS reportable guidelines, how to file a BDDS report, and evaluations forall accident/injury reports to ensure a higher level of monitoring with allincidents. Record of training forms will be completed as all trainings arefinalized. *Refer to Appendix C for Recordof Training form to be used*.	

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	home that are bullies or intimidating? Yeah, Well No...Are there any staff that have cussed in front of you? Yes. [GHS #4] told me to get my --- up. Do you like all your staff? [GHS #3] tells me that I'm the baddest one of all. She tells me to be quiet. [GHS #5] tells me that I stink when I have accidents, that he is tired of me." The 8/10/15 investigation was not reported to the administrator and to BDDS according to staff law. The investigation did not include investigating client B's allegations regarding GHS #3, GHS #4, and GHS #5. On 8/27/15 at 12:50pm, an interview with the DRS, the QIDP (Qualified Intellectual Disabilities Professional), and the Vice President of Residential Services (VPRS) was conducted. The DRS, QIDP, and the VPRS indicated the agency investigated a staff reported event of staff bullying on 8/10/15. The DRS indicated the facility followed the BDDS policy and procedure for allegations of abuse, neglect, and/or mistreatment. The DRS indicated the facility did not report to the administrator and/or to BDDS in accordance with State Law. 9-3-1(b)(5) 9-3-2(a)			

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W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview, for 1 of 1 unreported allegation reviewed for 8 of 8 clients (clients A, B, C, D, E, F, G, and H), the facility failed to thoroughly investigate an allegation of staff to client abuse, neglect, and/or mistreatment for clients A, B, C, D, E, F, G, and H. Findings include: On 8/25/15 at 8:45am, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and did not include the following allegation of abuse, neglect, and/or mistreatment for clients A, B, C, D, E, F, G, and H: -An 8/10/15 "Residential Services Investigation" indicated "Summary of Events: Staff members brought it to the attention of the DRS (Director of Residential Services) that staff member [name of GHS (Group Home Staff) #3] was being very difficult to work with. [The staff names] stated that [GHS #3] was being very intimidating towards other staff members." The investigation	W 0154	**Toensure that established agency policies and procedures for investigations arebeing implemented and executed as written, the following corrective action(s)will be implemented:** 1) Allinvestigations will be conducted in the manner outlined on the ResidentialServices Investigation Process. *Refer toAppendix D for process outline.* To ensure that all investigations areconducted in a uniform and consistent manner, all Residential House Managers,Qualified Development Disability Professionals, Nurses, the Director, and theResidential Services Coordinator will be trained on the newly establishedinvestigation process outline. *Refer toAppendix E for Record of Training form to be used in documenting training.*	09/27/2015

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	did not document client B's allegation of staff to client abuse, neglect, and/or mistreatment. -The 8/10/15 investigation included an interview with client B which indicated "Are there any staff that work in your home that are bullies or intimidating? Yeah, Well No...Are there any staff that have cussed in front of you? Yes. [GHS #4] told me to get my --- up. Do you like all your staff? [GHS #3] tells me that I'm the baddest one of all. She tells me to be quiet. [GHS #5] tells me that I stink when I have accidents, that he is tired of me." The 8/10/15 investigation was not thorough in that the investigation did not include investigating client B's allegations regarding staff to client abuse, neglect, and/or mistreatment by GHS #3, GHS #4, and GHS #5. On 8/27/15 at 12:50pm, an interview with the DRS (Director of Residential Services), the QIDP (Qualified Intellectual Disabilities Professional), and the Vice President of Residential Services (VPRS) was conducted. The DRS, QIDP, and the VPRS indicated the agency investigated a staff reported event of staff bullying on 8/10/15. The DRS indicated the facility did not investigate			

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	client B's allegation of staff mistreatment. 9-3-2(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 1 of 3 sampled clients (client A), the facility failed to implement client A's Individual Support Plan (ISP) and Behavior Support Plan (BSP) when opportunities existed. Findings include: On 8/25/15 at 8:45am, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and included the following suicide attempt incident for client A: -An 8/20/15 BDDS report for an incident on 8/20/15 at 6:15am, indicated the Group Home Staff (GHS) #1 "went into [client A's] room at 6:15am to wake her up and found her in her bed with a shoestring tied tight around her neck.	W 0249	**Toensure that individual plans for Client A are written to best fit her needs andto ensure that all individual plans for Client A are being followed as written,the following corrective action(s) will be implemented:** 1) TheDiagnostic and Evaluation forms (D&E) for Client A will be reviewed andrevisions to her Behavior Support Plans (BSP) will be completed to reflect pastinformation and present information needed for continuity of care. The revisedBSP will include historical information, additional targeted behaviors, CIPintervention, routine body checks, and a level system that will dictateinstructions for restrictions and supervision. Additionally, the QIDP will create a suicideideation/attempt risk plan with step by step instructions of which staffmembers to contact when Client A engages in this	09/27/2015

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	[Client A] was alert and breathing, but staff immediately cut off the string off her neck. [Client A] reported to staff I was trying to kill myself and was crying. Staff contacted the On Call and was instructed to start safety checks and remove all items [client A] could use to harm herself. Staff kept [client A] within line of sight and removed all strings, cords, and small items. Staff found three (3) light red marks around [client A's] neck." The report indicated client A's psychiatrist was contacted and recommended to take client A to the local Emergency Room (ER). The report indicated client A "once at the emergency room [client A] reported that she was still having suicidal thoughts and said I heard the devil say I was going to die." The report indicated client A "has a long history of engaging in these behaviors and they sometimes occur with no warning. It has been over 12 months since [client A] has engaged in any suicidal behavior...The psychiatrist chose to discontinue [client A's] Clozapine (for behaviors) on 7/28/15 due to [client A's] primary care physician's concern of anemia from [client A's] lab result." Client A's record was reviewed on 8/25/15 at 11:05am. Client A's 4/8/15 ISP and 4/2015 BSP both indicated her diagnoses included, but were not limited		type of behavior. All directcare staff working in the home will be promptly trained on any revisions oradditions to Client A's individual plans. Record of Training forms willcompleted once all trainings are finalized. **Toensure that client programs are implemented as written, the followingcorrective actions will be implemented:** 1) AllQualified Intellectual Disabilities Professionals (QIDP) within the ResidentialServices Department will office out of the same building as the ResidentialDirector and Residential Vice President to provide continuous and more thoroughadministrative oversight in their work. Additionally, the QIDP will spend adesignated amount of time each day in their assigned group home to provideone-on-one interaction with the clients, to ensure that designated plans areeffective and meet client needs, and to help administrative staff determine howwe may better meet individual client needs. 2) TheQIDP will meet with	

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	to: "Schizoaffective Disorder, Borderline Personality Disorder." Client A's ISP and BSP indicated targeted behaviors of "Self Injurious behavior/PICA (consuming inedible items), Suicidal Ideation/Attempt, Elopement, Self Deprecating Speech, and Giving Items Away." -Client A's ISP and BSP both indicated staff were to provide twenty-four hour staff supervision. Client A's BSP indicated "is an emancipated adult...has a long history of numerous placements due to elopement and self injurious behavior...has a history of various types of abuse including sexual abuse by her foster father resulting in pregnancy. She has a history of suicidal ideation and attempts. In the past [client A] attempted to jump out of a moving vehicle during times of depression. She climbed a fence and attempted to jump off a bridge in order to drown herself several years ago...Intervention...[Client A] should not have in her possession non edible items that she could swallow during periods of depression and decompensation. She should also not have access to strings, ties, ropes, cords, sharp objects, hazardous chemicals or objects that she could break during episodes of suicidal talk or decompensation...[Client A's] threats of suicide are often a result of		the Residential Director on a weekly basis to providestatus updates on client goals, individual plans, etc. and to provide theResidential Director the opportunity to review goals and plans and to makenecessary suggestions, changes, or revisions. Upon any changes, the QIDP will seekapproval from the Inter-Disciplinary Team. Once approved, the QIDP will then implementthe revised plans and provide immediate training to all direct care staffworking in the home. 3) TheResidential House Manager will review documentation of client programs on aweekly basis to ensure that programs and goals are being implemented aswritten. In the event that program goals and plans are not being implemented aswritten, the Residential House Manager will notify the QIDP who will in turn providere-training for all staff working in the home.	

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	impulsive actions or attention seeking. If she is attempting to seek attention...Any objects she could harm herself with will be removed and staff will provide constant supervision...." During observation on 8/25/15 from 6:40am until 8:10am at the group home, client A was not present. From 6:40am until 8:10am, client A's shared bedroom was observed to have two of two (2 of 2) windows each with blinds with four cords each hanging from the two window coverings. At 7:00am, GHS #1 indicated client A's two window blinds each had four (4) cords hanging from the blinds. GHS #1 stated client A was in the hospital "currently" after she attempted suicide on 8/20/15. GHS #1 stated client A was "upset and crying" the day before the incident. GHS #1 stated she was on duty at the group home on 8/20/15, discovered client A with the shoe strings tied "tight" around her neck, and she had to "cut" the shoe strings from client A's neck with scissors. GHS #1 stated client A had experienced increased behaviors of crying and "wanting to die" since "early" July, 2015. GHS #1 indicated client A's psychiatrist had been decreasing and changing her medications since early 7/2015. Confidential Interview (CI) #1 stated			

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	client A was "crying, upset, felt bad about herself, talked to staff, then went to bed" the evening before 8/20/15. CI #1 stated "then she tried to kill herself in the morning." On 8/27/15 at 12:50pm, an interview with the Director of Residential Services (DRS) was conducted. The DRS stated client A's psychiatrist had been changing client A's psychiatric medications beginning in "around June/July, 2015." The DRS indicated the change in psychiatric medications was due to client A's lab values and Anemia caused by the medications. The DRS stated "We saw increased behaviors" from client A regarding self deprovating talk, giving her items away, and thoughts of suicide. The DRS provided client A's behavior reports which indicated client A had experienced increased crying and behaviors in 7/2015 and 8/2015. The DRS stated client A was crying and "talked of self deprovation" on 8/2/15. The DRS stated on 8/20/15 client A "attempted suicide." The DRS stated "We never thought about the blinds in her room having cords" and indicated the cords will be removed. The DRS indicated client A's suicidal behaviors were known to the facility, her medication decreases were known to the facility, and the attempt occurred at the			

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	facility. The DRS indicated client A accessed her shoe strings, removed the strings from her shoes, and attempted to hang herself on 8/20/15. This federal tag relates to complaint #IN00180739. 9-3-4(a)			
W 0289 Bldg. 00	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. Based on observation, record review, and interview, for 1 of 3 sampled clients (client A) who had restrictive techniques employed, the facility failed to clearly define the specific techniques utilized in client A's Individual Support Plan (ISP) and Behavior Support Plan (BSP). Findings include: On 8/25/15 at 8:45am, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and included the following suicide attempt incident for client A: -A 8/20/15 BDDS report for an incident	W 0289	**Toensure that individual plans for Client A are written to best fit her needs andto ensure that all individual plans for Client A are being followed as written,the following corrective action(s) will be implemented:** 1) TheDiagnostic and Evaluation forms (D&E) for Client A will be reviewed andrevisions to her Behavior Support Plans (BSP) will be completed to reflect pastinformation and present information needed for	09/27/2015

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	on 8/20/15 at 6:15am, indicated the Group Home Staff (GHS) #1 "went into [client A's] room at 6:15am to wake her up and found her in her bed with a shoestring tied tight around her neck. [Client A] was alert and breathing, but staff immediately cut off the string off her neck. [Client A] reported to staff I was trying to kill myself and was crying. Staff contacted the On Call and was instructed to start safety checks and remove all items [client A] could use to harm herself. Staff kept [client A] within line of sight and removed all strings, cords, and small items. Staff found three (3) light red marks around [client A's] neck." The report indicated client A's psychiatrist was contacted and recommended to take client A to the local Emergency Room (ER). The report indicated client A "once at the emergency room [client A] reported that she was still having suicidal thoughts and said I heard the devil say I was going to die." The report indicated client A "has a long history of engaging in these behaviors and they sometimes occur with no warning. It has been over 12 months since [client A] has engaged in any suicidal behavior...The psychiatrist chose to discontinue [client A's] Clozapine (for behaviors) on 7/28/15 due to [client A's] primary care physician's concern of anemia from [client A's] lab result."		continuity of care. The revisedBSP will include historical information, additional targeted behaviors, CIPintervention, routine body checks, and a level system that will dictateinstructions for restrictions and supervision. Additionally, the QIDP will create a suicideideation/attempt risk plan with step by step instructions of which staffmembers to contact when Client A engages in this type of behavior. All directcare staff working in the home will be promptly trained on any revisions oradditions to Client A’s individual plans. Record of Training forms willcompleted once all trainings are finalized.	

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	Client A's record was reviewed on 8/25/15 at 11:05am. Client A's 4/8/15 ISP and 4/2015 BSP both indicated her diagnoses included, but were not limited to: "Schizoaffective Disorder, Borderline Personality Disorder." Client A's ISP and BSP indicated targeted behaviors of "Self Injurious behavior/PICA (consuming inedible items), Suicidal Ideation/Attempt, Elopement, Self Deprecating Speech, and Giving Items Away." -Client A's ISP and BSP both indicated staff were to provide twenty-four hour staff supervision. Client A's BSP indicated "is an emancipated adult...has a long history of numerous placements due to elopement and self injurious behavior...has a history of various types of abuse including sexual abuse by her foster father resulting in pregnancy. She has a history of suicidal ideation and attempts. In the past [client A] attempted to jump out of a moving vehicle during times of depression. She climbed a fence and attempted to jump off a bridge in order to drown herself several years ago...Intervention...[Client A] should not have in her possession non edible items that she could swallow during periods of depression and decompensation. She should also not have access to strings,			

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	ties, ropes, cords, sharp objects, hazardous chemicals or objects that she could break during episodes of suicidal talk or decompensation...[Client A's] threats of suicide are often a result of impulsive actions or attention seeking. If she is attempting to seek attention...Any objects she could harm herself with will be removed and staff will provide constant supervision...." Client A's plans did not define who could authorize the removal/return of client A's items based on her behaviors, room sweeps monitoring, staff supervision levels when client A displayed self injurious behaviors, and the restricted techniques employed. Client A's plans did not define the length of time for client A's "depression and decompensation" periods before returning items and changing staff supervision levels. During observation on 8/25/15 from 6:40am until 8:10am at the group home, client A was not present. From 6:40am until 8:10am, client A's shared bedroom was observed to have two of two (2 of 2) windows each with blinds with four cords each hanging from the two window coverings. At 7:00am, GHS #1 indicated client A's two window blinds each had four (4) cords hanging from the blinds. GHS #1 stated client A was in the hospital "currently" after she attempted			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G789	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/28/2015
NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 3770 W 80 N KOKOMO, IN 46901	

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	suicide on 8/20/15. GHS #1 stated client A was "upset and crying" the day before the incident. GHS #1 stated she was on duty at the group home on 8/20/15, discovered client A with the shoe strings tied "tight" around her neck, and she had to "cut" the shoe strings from client A's neck with scissors. GHS #1 stated client A had experienced increased behaviors of crying and "wanting to die" since "early" July, 2015. GHS #1 indicated client A's psychiatrist had been decreasing and changing her medications since early 7/2015. Confidential Interview (CI) #1 stated client A was "crying, upset, felt bad about herself, talked to staff, then went to bed" the evening before 8/20/15. CI #1 stated "then she tried to kill herself in the morning." On 8/27/15 at 12:50pm, an interview with the Director of Residential Services (DRS) was conducted. The DRS stated client A's psychiatrist had been changing client A's psychiatric medications beginning in "around June/July, 2015." The DRS indicated the change in psychiatric medications was due to client A's lab values and Anemia caused by the medications. The DRS stated "We saw increased behaviors" from client A regarding self deprovating talk, giving			

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	her items away, and thoughts of suicide. The DRS provided client A's behavior reports which indicated client A had experienced increased crying and behaviors in 7/2015 and 8/2015. The DRS stated client A was crying and "talked of self deprovation" on 8/2/15. The DRS stated on 8/20/15 client A "attempted suicide." The DRS stated client A's plans "did not include" a definition for who could authorize the removal/return of client A's items based on her behaviors, room sweeps monitoring, staff supervision levels when client A displayed self injurious behaviors, and the restrictive techniques employed. The DRS stated client A's plans "did not define" the length of time for client A's "depression and decompensation" periods before returning items and changing staff supervision levels. The DRS stated "We just missed those components" in client A's plans. The DRS stated "We never thought about the blinds in her room having cords" and indicated the cords will be removed. The DRS indicated client A's suicidal behaviors were known to the facility, her medication decreases were known to the facility, and the attempt occurred at the facility. The DRS indicated client A accessed her shoe strings, removed the strings from her shoes, and attempted to hang herself on			

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	8/20/15. This federal tag relates to complaint #IN00180739. 9-3-5(a)			