

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G586		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/22/2013	
NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN 46904			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: November 12, 13, 14, 15, and 22, 2013.</p> <p>Provider Number: 15G586 Facility Number: 001100 AIM Number: 100240050</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 3, 2013 by Dotty Walton, QIDP.</p>	W000000					

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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W000104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review, and interview, for 4 of 4 clients (clients #1, #2, #3, and #4) and 4 additional clients (clients #5, #6, #7, and #8) who lived in the group home, the governing body failed to exercise operating direction over the facility to complete maintenance and repairs at the group home for doors, walls, bathroom ceiling frames, and carpets.</p> <p>Findings include:</p> <p>During observations on 11/12/13 from 2:35pm until 6:10pm, and on 11/13/13 from 6:50am until 8:15am, clients #1, #2, #3, #4, #5, #6, #7, and #8 were inside the group home and the following maintenance needs were identified with the Group Home Manager (GHM):</p> <p>-The living room carpet had stains and on 11/12/13 at 2:35pm, the GHM stated "throughout" the carpeted area of the living room. The living room carpet had three (3) brown dark colored stains: One stain 8'x3 1/2' (eight feet by three and one half foot), one stain 4'x2' (four feet by two feet), and one stain 3'x3' (three feet by three feet).</p> <p>-The kitchen, dining room, living room,</p>	W000104	<p>The ongoing maintenance of the physical structure does have a monitoring system in place. The repair items cited by the surveyor were already identified and the gathering of estimates and scheduling of work had already begun. The physical structures are reviewed weekly and monthly in the following manner:</p> <p>1. Residential house manager completes a weekly safety report that is for the express purpose of reporting maintenance issues. The form was updated to include a section to report carpet stains and paint needs (Appendix J). This is sent to the Director of Residential Services, the Vice President for Community and Social Services, the Senior Vice President, and the Coordinator of Maintenance.</p> <p>2. The Director of Residential Services and VP of Community and Social Services complete a monthly environmental checklist. (Appendix K). This checklist was provided to the surveyor and indicates the need for the repairs.</p> <p>3. The maintenance department completes a preventative maintenance checklist (Appendix L). All of these checks are in place to identify needed maintenance issues. On</p>	12/22/2013			

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	<p>and hallway walls of the interior of the group home had paint peeling with black marks, and on 11/12/13 at 2:35pm, the GHM stated "the finish worn, and needed repainted."</p> <p>-On 11/12/13 at 2:35pm, the GHM stated the drop ceiling frame inside the north bathroom was rusted and "needed to be painted or replaced."</p> <p>-The drop ceiling frame inside the south bathroom was rusted.</p> <p>-The bedroom doors for clients #1, #2, #3, #4, #5, #6, #7, and #8 had marks, gouges, worn finish, and damage to the wood.</p> <p>-On 11/12/13 at 2:35pm, the GHM stated client #2 and #4's shared bedroom carpet was "stained and worn."</p> <p>-At 2:35pm, GHM stated client #5 and #6's shared bedroom carpet was "stained and worn."</p> <p>-At 2:45pm, GHM stated client #7 and #8's shared bedroom carpet was "stained and worn."</p> <p>-At 2:45pm, GHM stated client #1 and #2's shared bedroom carpet was "worn." GHM stated client #3's bookshelf wood finish was "worn" and there was "damage" to the wood.</p> <p>-The doors to the north and south hallway bathrooms had marks, gouges, and damage to the wood.</p> <p>-The doors in the dining room and hallway closet had marks, gouges, and had damage to the wood.</p>		<p>December 11, 2013, Hochstetler's Flooring came to thehome to prepare an estimate to replace carpeting in the living room, hallwaysand all client bedrooms. Hochstetler'sindicated that the replacement date would be January 15, 2014. Interior walls were inspected for paint touch ups. No peeling paint was found in any of the roomsindicated on the survey. Walls were in good repair, with no peeling,with the exception of one spot where a client chair sits and has rubbed paintoff (1 inch by 6 inches). This will betouched up by 12/22/12. No black marks were noted but staff have beeninstructed to clean them should they occur. This is sometimes caused by being rubbed by a wheelchair. Interior walls will all be repainted byJanuary 21, 2014.The drop ceiling frames will be scrubbed and repainted,doorway frames to be replaced and rear door replacement all scheduled forcompletion.</p>				

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	<p>-The rear exit door to the rear driveway where clients #1, #2, #3, #4, #5, #6, #7, and #8 entered and exited with the facility staff was rusted and had damage to the finish.</p> <p>On 11/13/13 at 11:30am, the facility's maintenance items to be repaired and/or replaced was requested from the QIDP (Qualified Intellectual Disabilities Professional). The QIDP provided a 10/30/13 "Environmental Checklist" which indicated:</p> <p>-The living room "carpet to be included in capital improvement plan." -The "Walls of the interior (of the group home) need to be repainted." -The drop ceiling frames in the north and south bathrooms "has rusted. Needs to be painted or replaced (sic)." -"Four doorways: 2 bedrooms, hallway, and south bathroom need to be replaced with metal frames." -The "rear exit door" to the the rear driveway "are rusted, quote for replacement (sic)."</p> <p>On 11/13/13 at 11:30am, an interview with the QIDP and the DRS (Director of Residential Services) was conducted. The QIDP and the DRS both indicated the list documented of needed maintenance and repairs to the group home were correct. The DRS indicated the agency was</p>			

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	<p>completing a capital improvement list for needed repairs of the group home.</p> <p>9-3-1(a)</p>				

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W000126	<p>483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.</p> <p>Based on observation, interview, and record review, for 1 of 1 sampled clients (client #1) and 3 additional clients (clients #5, #7, and #8) who attended the classroom area of the workshop, the facility failed to use United States Currency to implement individual support plan (ISP) goals/objectives for money skills training for clients #1, #5, #7, and #8.</p> <p>Findings include:</p> <p>During observation on 11/12/13 from 12:50pm until 2:20pm, observations at the workshop were completed for client #1, #5, #7, and #8's classroom. At 1:15pm, clients #1, #5, #7, and #8 were prompted to use brown plastic discs, silver plastic discs, lime green paper with \$1.00, \$5.00, and \$10.00 on the non United States Currency items. Clients #1, #5, #7, and #8 were prompted to identify plastic disc coins and lime green paper, state their value, and count each item of non United States Currency. Workshop Staff (WKS) #1 and WKS #2 both indicated clients #1, #5, #7, and #8's ISP</p>	W000126	Day program staff (Community Connections) has already disposed of the fake currency and has obtained real currency that is set aside specifically for the purpose of supporting clients to manage financial affairs and teach them to do so within the extent of their capabilities. All staff will be retrained on the appropriate way to support financial goals on 12/19/13. The Community Connections QDDP will monitor for compliance with biweekly observation (Appendix M) for 90 days. If there are no issues with compliance at that time, monitoring will be completed via monthly reports.	12/22/2013

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	<p>(Individual Support Plan) goals/objectives were not run with the use of United States Currency. Both workshop staff stated the "play money" did not have the same texture, weight, or visual identification of United States Currency.</p> <p>Client #1's record was reviewed on 11/13/13 at 10:50am. Client #1's 7/10/13 ISP (Individual Support Plan) indicated an objective for client #1 to identify to staff the correct coin in a group of coins by pointing.</p> <p>An interview with the QIDP (Qualified Intellectual Disabilities Professional) and DRS (Director of Residential Services) was conducted on 11/14/13 at 10:40am. The QIDP and the DRS both indicated United States Currency should have been used for clients #1, #5, #7, and #8 during formal and informal opportunities to teach clients about currency and to identify coins and dollar bills. The QIDP and DRS both indicated play money should not have been used. The QIDP indicated each program should have been implemented with United States Currency.</p> <p>9-3-2(a)</p>				

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W000130	<p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>Based on observation and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and for 4 additional clients (clients #5, #6, #7, and #8), the facility failed to encourage and teach personal privacy during client #1, #2, #3, #4, #5, #6, #7, and #8's medication administration.</p> <p>Findings include:</p> <p>On 11/12/13 from 3:46pm until 4:30pm, and on 11/13/13 from 7:10am until 8:00am, clients #1, #2, #3, #5, #6, #7, and #8 had their evening and morning medications administered by GHS (Group Home Staff) #1 in the living room of the group home. During both of the medication administration times clients #1, #2, #3, #4, #5, #6, #7, and #8 sat in recliners and wheelchairs in the living room a few feet from the medication cart, stood at the medication cart while other clients had their medications administered, and walked up to the staff administering another clients medications to ask a question of the staff. Throughout both observation periods, clients #1, #4, #5, #6, and #8 walked and/or stood within</p>	W000130	A portable screen has been purchased to provide privacy to clients during medication administration. All staff will be trained on 12/19/13 on the proper use of privacy screen during medication administration to protect client privacy. The Residential House Manager, QDDP or Residential Nurse will monitor for compliance with biweekly observation (Appendix N) for 90 days. If there are no issues with compliance at that time, observation will be completed intermittently for 8 additional weeks. If there are any issues with compliance during this time, staff will begin biweekly observations again to ensure compliance. If no issues with compliance during 5 month monitoring, formal documentation will be discontinued.	12/22/2013			

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	<p>a few feet of the medication cart while other clients had their medications administered, described, and/or discussed. On 11/13/13 at 7:55am, client #2 had an injectable medication administered by GHS #1 in full view of clients #1, #3, #4, #5, #6, #7, and #8 who sat and/or stood in the living room. GHS #1 prompted client #2 to raise her shirt to expose her midriff, GHS #1 pulled client #2's skin together, and then GHS #1 injected client #2's "Enoxaparin 80/0.8m (blood thinner) 1 injectable subcutaneously" daily. During both observation periods clients #1, #2, #3, #4, #5, #6, #7, and #8 watched the medications administered and interrupted one another with verbal discussions between clients from the living room with clients who were receiving their medications without redirection.</p> <p>On 11/14/13 at 10:40am, an interview the QIDP (Qualified Intellectual Disabilities Professional) and the DRS (Director of Residential Services) was conducted. The QIDP and the DRS both indicated clients should have privacy and be taught personal privacy during their medication administration. The DRS indicated the group home did not have a private area for medications to have been administered.</p>						

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W000140	<p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview, for 1 of 4 sample clients (client #4) who had personal money entrusted to the facility, the facility failed to ensure an accurate accounting of client #4's personal funds and failed to follow their policy and procedure for client finances.</p> <p>Findings include:</p> <p>On 11/12/13 at 11:00am, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations from 11/2012 through 11/12/13 were reviewed and indicated the following for client #4.</p> <p>-A 5/17/13 BDDS report for an incident on 5/16/13 at 11:00am, indicated client #4's money pouch was missing. The report indicated each shift of facility personnel at the group home had signed client #4's financial record to indicate client #4's money was counted and accounted for on 5/14/13, 5/15/13, 5/16/13, and 5/17/13. The report indicated client #4 had went on an outing with her assigned facility staff and with her money pouch on 5/14/13. The report</p>	W000140	<p>Staff member responsible for missing money was terminated based on the outcome of the investigation which indicated failure to follow money policy. Staff who signed documentation that they had counted the money were re-trained on money policy and received corrective action. All staff will be retrained on money policy on 12/19/13. To monitor for continued compliance, Residential House Manager will review staff documentation of consumer funds and will count the money on a biweekly basis. This will be documented on Appendix O.</p>	12/22/2013			

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	<p>indicated on 5/16/13 at 11:00am the House Manager (HM) could not locate client #4's money pouch for the HM to count client #4's money. The report indicated the HM began to back track client #4's outings and expenses. The HM notified the DRS (Director of Residential Services).</p> <p>-An undated investigation for client #4's missing money pouch indicated client #4 went on an outing on 5/14/13 with her assigned staff person. The investigation indicated that staff person indicated she had returned client #4's money pouch after the outing. The investigation indicated other facility personnel who had worked in the home were interviewed. Those staff persons indicated they did not actually count client #4's money after the outing and client #4's money was not counted on 5/14/13, 5/15/13, 5/16/13, or 5/17/13. The investigation indicated those staff people were suspended pending the investigation results for not following the agency policy and procedure for client finance. The investigation indicated the staff person who took client #4 on the outing on 5/14/13 was re-interviewed. That staff changed her statement to indicate she had not returned client #4's money pouch after the outing and that staff person had located client #4's money pouch on</p>						

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	<p>5/19/13 inside the staff's purse. Client #4's money pouch was returned on 5/19/13 and client #4's balance of \$39.98 was inside the money pouch. The investigation indicated that the staff who returned client #4's money pouch was suspended and retrained on the facility policy and procedure for client finance.</p> <p>On 11/14/13 at 10:40am, the facility's policy and procedure 10/2011 "Money & Receipt Procedure" indicated "Staff will be held accountable for providing the Residential Manager with original receipts and change...Staff will count the money that is in the cash box at each shift change. The amount in the cash box will be documented on the main ledger. Another staff on duty will count the money in the cash box to verify and document as witness. The designated key holder will distribute the money for outings, shopping, etc...The staff responsible for the consumers' money/receipts will sign the cash receipt for money taken from. Upon returning home from the purchase, the staff will give change and receipts to the designated key holder to return to the cash box. The staff returning the money/receipts from the purchase will sign the cash receipt for money returned form...Two staff will again document that the money and receipts have been returned...."</p>						

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	<p>An interview on 11/14/13 at 10:40am, was conducted with the DRS (Director of Residential Services). The DRS indicated client personal funds accounts were kept separate for each client. The DRS indicated client #4's money and money pouch were missing from 5/14/13 until it was returned on 5/19/13. The DRS indicated the facility's personal funds policy and procedure was not followed by the facility staff because the staff failed to return the money and receipts to client #4's secure money box after the outing. The DRS indicated the facility staff failed to follow the facility's policy and procedure for a full and accurate accounting when the other facility staff continued to sign the money was counted when the money was missing.</p> <p>9-3-2(a)</p>						

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W000153	<p>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 19 BDDS (Bureau of Developmental Disabilities Services) reports reviewed for 1 of 1 allegations of abuse/neglect/and or mistreatment affecting 1 of 4 sampled clients (client #4), the facility failed to immediately report an allegation of mistreatment to BDDS and to the administrator in accordance with State Law.</p> <p>Findings include:</p> <p>On 11/12/13 at 11:00am, the facility's BDDS Reports and investigations were reviewed from 11/1/12 through 11/12/13 and indicated the following:</p> <p>-A 5/14/13 BDDS report for an incident on 5/11/13 at 8:00pm, indicated "On 5/13/13 at 2:15pm, during a one on one conversation with [GHS (Group Home Staff) #99] she was asked by the House Manager if there were any staffing issues that are causing difficulties in the house. [GHS #99] mentioned situations concerning [GHS #98's] attitude towards</p>	W000153	<p>Direct care staff did not follow agency policy on incident reporting and received corrective action for failing to do so. Staff were retrained in May 2013 on the regulation that incidents must be reported immediately. Staff will be retrained on policy on 12/19/13. To monitor compliance to this policy, each staff member is re-trained annually on the BDDS guidelines for reporting. This is tracked by each supervisor and overseen by the Lead Residential Staff Supervisor. To ensure continued compliance, the QDDP will complete a review of daily notes to monitor for any issues that might be BDDS reportable (Appendix P). In the event, an issue is discovered, the Director will be contacted immediately and a BDDs report will be filed.</p>	12/22/2013			

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	<p>other staff. At this point, [GHS #99] was asked how [GHS #98's] attitude is toward the consumers. [GHS #99] then reported that she witnessed last Saturday on 5/11/13 that [GHS #97] was assisting an (unidentified) consumer to the bathroom to be changed when [client #4] went to the bathroom before they reached the bathroom. It was also reported that [GHS #98] went into the bathroom and grabbed [client #4] by her arms pulling her off the toilet seat. [Client #4] kept stating 'NO' as she was trying to pull away, [GHS #99] stated she was afraid that [GHS #98] would let go while pulling her that she [GHS #99] placed her hand on [client #4's] back in case [client #4] falls (sic). [Client #4] had a free hand during this incident and tried to hit [GHS #98]." The report indicated GHS #97 was a third staff who was present during the incident and GHS #97 indicated her back was turned so she did not see the incident. GHS #97 stated "At one point (she) heard [client #4] say 'No' and 'I'll pull your hair'." GHS #99 stated she "also witnessed [GHS #98] pulling her into the dining room and then released [client #4]."</p> <p>-An undated investigation indicated the allegation of abuse, neglect, and/or mistreatment was "not substantiated." The staff were retrained to immediately report all allegations to the administrator</p>			

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	<p>and other agencies (BDDS) in accordance with State Law.</p> <p>On 11/14/13 at 10:40am, an interview was conducted with the Director of Residential Services (DRS). The DRS indicated client #4's allegation was unsubstantiated and staff were retrained to immediately report all allegations of abuse, neglect, and/or mistreatment. The DRS indicated staff failed to immediately report allegations timely for client #4.</p> <p>9-3-1(b)(5) 9-3-2(a)</p>				

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W000225	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include, as applicable, vocational skills. Based on observation, interview, and record review, for 1 of 4 sampled clients (client #4), the facility failed to assess client #4's active treatment needs for vocational skills.</p> <p>Findings include:</p> <p>On 11/12/13 from 2:35pm until 6:10pm, client #4 was observed at the group home with the facility staff. From 2:35pm until 4:00pm, client #4 sat/stood in the living room and dining room. Client #4 folded laundry, watched television, and stirred her drink mixture with Group Home Staff (GHS) #1.</p> <p>On 11/13/13 from 8:50am until 11:35am, client #4 was observed at the group home. Client #4 stirred coffee, looked at the newspaper, watched television, and left with Group Home staff for shopping in the community.</p> <p>On 11/14/13 at 11:10am, client #4's record was reviewed. Client #4's 8/14/13 ISP (Individual Support Plan) did not include a vocational goal/objective. Client #4's "Vocational Assessment" was not available for review.</p>	W000225	Client functional risk assessment has been updated to include vocational assessment information (Appendix A). Additionally, client #4 ISP has been updated (Appendix B) to include statement on vocational assessment. All staff will be retrained on updated documents on 12/19/13. To ensure continued compliance, vocational assessment has been added to the risk assessment tool that is completed for every consumer annually and is reviewed quarterly (Appendix Q). Additionally, residential QDDP's meet monthly with day program QDDP's to review progress/issues at workshop and at Community Connections day program. Minutes from these meetings are maintained by the day program QDDP's. No other consumers were identified as being affected by the deficient practice.	12/21/2013			

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	<p>On 11/14/13 at 11:10am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client #4 had a medical illness and had not attended workshop for over 30 days. The QIDP indicated client #4's assessment and development of her goals/objectives had not been reviewed/revised. The QIDP indicated no further vocational information for client #4 was available.</p> <p>9-3-4(a)</p>			

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W000250	<p>483.440(d)(2) PROGRAM IMPLEMENTATION</p> <p>The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. Based on observation, interview, and record review, for 1 of 4 sampled clients (client #4), the facility failed to develop an active treatment schedule which included what staff were to do with the client during the day and to indicate what training was to occur with client #4.</p> <p>Findings include:</p> <p>On 11/12/13 from 2:35pm until 6:10pm, client #4 was observed at the group home with the facility staff. From 2:35pm until 4:00pm, client #4 sat/stood in the living room and dining room. Client #4 folded laundry, watched television, and stirred her drink mixture with Group Home Staff (GHS) #1.</p> <p>On 11/13/13 from 8:50am until 11:35am, client #4 was observed at the group home. Client #4 stirred coffee, looked at the newspaper, watched television, and left with Group Home staff for shopping in the community. At 8:50am, GHS #1 indicated client #4 did not have an active treatment schedule for the group home to indicate</p>	W000250	<p>An active treatment schedule was developed for client #4 (Appendix C). The risk assessment (Appendix A) was updated to reflect revised active treatment schedule. Additionally, client #4 ISP has been updated (Appendix B) to reflect the active treatment schedule. To monitor continued compliance, vocational assessment/active treatment schedule was added to the risk assessment tool which is revised annually and reviewed quarterly (Appendix Q). Additionally, active treatment goals are reported on monthly to the Director of Residential Services. A line was added to the monthly report template (Appendix R) for reporting on Daily Active Treatment concerns. Monthly reports are completed by QDDP and reviewed by Director of Residential. No other consumers were identified as being affected by the deficient practice.</p>	12/22/2013			

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	<p>what she was to complete and/or what training was to have occurred.</p> <p>On 11/14/13 at 11:10am, client #4's record was reviewed. Client #4's 8/14/13 ISP (Individual Support Plan) did not include an active treatment schedule to direct activities and training during day hours at the facility.</p> <p>On 11/14/13 at 11:10am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated no further information regarding client #4's schedule for active treatment was available for review. The QIDP indicated client #4 had a medical illness and had not attended workshop for over 30 days. The QIDP indicated client #4's assessment and development of her goals/objectives had not been reviewed/revised. The QIDP indicated client #4 did not have an active treatment schedule for staff to follow for day services provided at the group home.</p> <p>9-3-4(a)</p>				

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W000289	<p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>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 record review and interview, for 1 of 2 sampled clients (client #2) who had restrictive techniques employed, the facility failed to clearly define the specific techniques utilized in client #2's Behavior Support Plan (BSP).</p> <p>Findings include:</p> <p>Client #2's records were reviewed on 11/15/13 at 9:30am. Client #2's 8/6/2013 ISP (Individual Support Plan) and 8/2013 BSP (Behavior Support Plan) indicated client #2's behaviors included irritability, self injurious behaviors "which included any form of self harm that is intentional, head banging, touching hot items, biting self, throwing self against doors/walls or attempting to cut self," and physical aggression. Client #2's BSP indicated "...Intervention...Do not attempt to move [client #2] when she is having a tantrum unless there is a health or safety concern. Use blocks in CPI (Crisis Prevention Intervention) class to prevent clients and staff from being hurt by [client #2] grabs or strikes...Note: please keep the safety of</p>	W000289	<p>Client #2's BSP has been updated(Appendix D) to include systematic interventions to manage inappropriatebehavior. Specifically language has beenincluded to specify and give examples of least restrictive to most restrictiveinterventions. Each consumer's annualdocumentation, including BSP, is reviewed at least annually by Director anddocumented on Residential Annual Checklist (Appendix S). Additionally, all BSP's are reviewed twiceeach year by Human Rights Committee. Further, Bona Vista programs recently hired a Behavior Specialist whowill review BSP's annually.</p>	12/22/2013

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	<p>[client #2], the other consumers, and staff in mind when intervention becomes necessary. Use approved CPI techniques for interventions." Client #2's plan failed to indicate and define specifically what CPI techniques were to be used. Client #2's plan failed to define a written description of the hierarchy from least restrictive to most intrusive techniques used.</p> <p>On 11/15/13 at 12 noon, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the DRS (Director of Residential Services) was conducted. Both professional staff indicated no documented evidence which described written interventions from least restrictive to most intrusive techniques staff were to employ for client #2's behaviors. Both staff indicated client #2's BSP did not state and/or define the specific techniques used for client #2.</p> <p>9-3-5(a)</p>			

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W000317	<p>483.450(e)(4)(ii) DRUG USAGE Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated. Based on record review and interview, for 2 of 2 sampled clients (clients #2 and #4) who received psychotropic medications, the facility failed to evaluate client #2 and #4's status for an annual decrease or contraindication for decrease of psychotropic medications.</p> <p>Findings include:</p> <p>1. Client #2's record was reviewed on 11/15/13 at 9:30am. Client #2's 8/6/13 ISP (Individual Support Plan) and 8/2013 BSP (Behavior Support Plan) indicated the targeted behaviors of irritability, self injurious behaviors "which included any form of self harm that is intentional, head banging, touching hot items, biting self, throwing self against doors/walls or attempting to cut self," and physical aggression. Client #2's plans indicated the use of Lorazepam 0.5mg (milligrams) twice a day for generalized anxiety disorder. Client #2's 10/16/13, 7/30/13, 5/7/13, 2/12/13, and 10/15/12 "Psych (Psychiatric) Medication Reviews" did not indicate a change in client #2's</p>	W000317	Client #2's psychiatric medications have not been changed in over a year. However, the psychiatrist statement dated 10/16/13 indicated that "psychiatric medication changes were contraindicated because of..."consistent agitation" (Appendix E). The survey indicates that "client #4's psychiatric medication had not been changed in over a year and nocontraindication". Client #4 had medication review with Dr. Dzera on 9/23/13 (Appendix F) who indicated review of medication and indicated no medication changes due to stability on current meds (a contraindication). To monitor continued compliance the current physician form was modified in October 2013 to include the specific wording that changes are either needed or contraindicated (Appendix G).	12/22/2013			

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	<p>psychiatric medications or a contraindication. Client #2's 10/31/13 "Physician's Order" indicated client #2's Lorazepam 0.5mg twice a day for generalized anxiety disorder. Client #2's record did not indicate the last psychotropic medication change or contraindication. Client #2's targeted behavior data indicated: Extreme Irritability behavior: 9/13 was 18, 8/13 was 15, 7/13 was 11, 6/13 was 6, 5/13 was 6, and 4/13 was zero. Self Injurious behavior data: 9/13 was 1, 8/13 was zero, 7/13 was 2, 6/13 was 1, 5/13 was zero, and 4/13 was zero. Physical Aggressive behavior data: 9/13 was zero, 8/13 was 4, 7/13 was 3, 6/13 was 2, 5/13 was 2, and 4/13 was zero.</p> <p>Client #2's BSP indicated when client #2 had less than five (5) incidents of Extreme Irritability, less than one (1) incident of Physical Aggression, and less than six (6) incidents of Self Injurious Behavior "in a three month period" then a reduction of client #2's psychotropic medication would be considered. Client #2's record did not indicate a contraindication for a drug withdrawal.</p> <p>Interview with the DRS (Director of Residential Services) was conducted on 11/22/13 at 1:39pm. The DRS indicated client #2's psychiatric medication had not</p>						

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	<p>been changed in over a year and no contraindication for an attempt at a gradual reduction of client #2's psychiatric medication had been documented.</p> <p>2. Client #4's record was reviewed on 11/14/13 at 11:10am. Client #4's 8/14/13 ISP and 8/2013 BSP indicated the targeted behaviors of extreme irritability, run or wanders away, and physical aggression. Client #4's plans indicated the use of Abilify 5mg twice a day for behaviors and Paxil 10mg one and one half tablets once a day for behaviors. Client #4's 9/23/13, 7/1/13, 4/8/13, 1/7/13, and 10/15/12 "Psych (Psychiatric) Medication Reviews" did not indicate a change in client #4's psychiatric medications or a contraindication. Client #4's 10/31/13 "Physician's Order" indicated client #4's Abilify 5mg twice a day for behaviors and Paxil 10mg one and one half tablets once a day for behaviors. Client #4's record did not indicate the last psychotropic medication change or contraindication. Client #4's behavioral data of targeted behaviors indicated the following: Extreme Irritability: 9/13 was 3, 8/13 was 4, and 7/13 was 17 incidents. AWOL (Absent Without Leave Behaviors): 9/13 was zero, 8/13 was zero, and 7/13 was zero incidents. Physical Aggression: 9/13 was zero, 8/13</p>			

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	<p>was zero, and 7/13 was zero incidents. Client #4's BSP indicated when client #4 had less than twenty (20) incidents of Extreme Irritability, less than one (1) incident of Physical Aggression, and less than one (1) incident of leaving the area "in a three month period" then a reduction of client #4's psychotropic medications would be considered.</p> <p>Interview with the DRS (Director of Residential Services) was conducted on 11/22/13 at 1:39pm. The DRS indicated client #4's psychiatric medication had not been changed in over a year and no contraindication for an attempt at a gradual reduction of client #4's psychiatric medication had been documented.</p> <p>9-3-5(a)</p>				

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W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview, for 1 of 4 sampled clients (client #1), the facility's nursing services failed to ensure the inclusion of client #1's choking risk in client #1's plan and to complete immediate medical follow up after the Heimlich maneuver was used when client #1 choked.</p> <p>Findings include:</p> <p>On 11/12/13 at 11:00am, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 11/2012 through 11/12/2013 were reviewed and indicated the following for client #1.</p> <p>-A 1/10/13 BDDS report for an incident on 1/9/13 at 6:00pm, indicated client #1 choked at the supper meal at the group home on "a piece of skinless BBQ Chicken." The report indicated client #1 started to choke on a piece of boneless skinless piece of BBQ Chicken. The report indicated a staff "heard [client #1] at the table and others coming over to [client #1]. Staff found that [client #1] was not breathing or coughing and starting to panic." The staff person patted client #1's "back between his shoulders 1</p>	W000331	<p>The nurse who failed to provide timely assessment of client #1 is no longer working for Bona Vista. Client #1 has a current and appropriate choking protocol in place (Appendix H). Client #1's current choking plan includes the agency protocol that in the event of a choking incident a consumer is to be assessed by a physician to ensure no aspiration of food into lungs. All staff will be retrained on choking risk plan on 12/19/13. To monitor for continued compliance, all risk plans are submitted to the Director of Residential Services for review when completed (Appendix S). Review of all risk plans by Director also happens upon admission of a new client. Additionally, all BDDS incident reports are reviewed by an Incident Report Review committee for an additional layer of monitoring. The Incident Report Review committee meets monthly.</p>	12/22/2013	

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	<p>time but she could not get him to bend down far enough. [The staff person] then reached her hands around [client #1] and gave one thrust above his belly and under his breast bone when a piece of chicken shot out. [Client #1] began to breathe. After this she gave [client #1] a sip of juice to drink."</p> <p>-A 1/17/13 Follow up BDDS report to the 1/9/13 incident for client #1 indicated client #1 consumed his food at "a fast pace with a large piece of chicken about a quarter size (sic)." The report indicated "The plan in place [for client #1] was a dysphagia plan. Upon chart review, it was found that [client #1] does not have a Dysphagia diagnosis. [Client #1's] plans were updated by the [Agency Nurse] and the [QIDP (Qualified Intellectual Disabilities Professional)] to reflect proper diagnosis and risk. Plans written include dining plan and choking plan."</p> <p>-A 1/31/13 Follow up BDDS report to the 1/9/13 incident for client #1 indicated the staff "had not cut" client #1's food into "proper size" at the meal on 1/9/13. The report indicated client #1's dining plan at the time of the incident did not indicate "bite size" or "dime size" bites of food and client #1's chicken breast was cut into quarter size pieces. The report indicated</p>						

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	<p>client #1's personal physician did not identify Dysphagia as a diagnosis and had ordered a Swallow Study to be completed on 2/13/13 after the choking incident.</p> <p>Client #1's record was reviewed on 11/13/13 at 10:50am. Client #1 had a Medical Appointment with his attending physician on 1/11/13 to follow up on the incident on 1/9/13 when client #1 choked, "aspirated a unchewed piece of chicken breast into his airway, failed to breathe," and required the "Heimlich Maneuver to dislodge a piece of boneless chicken breast blocking" client #1's airway at the group home. Client #1's physician performed a chest X-ray to rule out client #1 aspirating food into his lungs and follow up from the staff performing the Heimlich Maneuver. Client #1's 2/24/13 Swallow Study indicated his chewing and swallowing were within normal limits. Client #1's record indicated he was admitted to the facility on 6/15/12 and had a 6/2012 "Dysphagia Plan" which indicated "encourage [client #1] to take small bites and verbal cues to swallow being careful to watch for swallow response." Client #1's dining plan was revised on 1/14/13 after he choked on a quarter size piece of boneless chicken breast. Client #1's 1/14/13 "Dining Plan" indicated his "food was to take small dime size bites (sic)." Client #1's 7/10/13</p>						

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	<p>"Choking Management Plan" indicated client #1 "has a history of eating quickly and not chewing well. He tends to pocket food in his cheeks...staff may offer [client #1] small amounts at one time. Staff will cut his food up and place his meal on two plates instead of one. This will ensure that [client #1] is only offered small amounts at one time. As he finishes one plate he will be given the other one...."</p> <p>On 11/13/13 at 10:50am, an interview with the DRS (Director of Residential Services) was conducted. The DRS indicated client #1 choked and failed to breathe on 1/9/13 on a quarter size piece of boneless chicken breast. The DRS stated the facility staff performed the Heimlich Maneuver and client #1 had "no medical" interventions until 1/11/13 when he was seen by his attending physician. The DRS indicated client #1 was not seen by the facility nurse. The DRS indicated the agency had changed its policy and procedure before this incident to immediately send the client who had choked and required the Heimlich to the hospital or urgent care for medical follow up to ensure the client had not aspirated or suffered injury from the Heimlich intervention. The DRS indicated client #1 was at risk to choke since admission on 6/15/12 because he consumed his meal at a fast rate of speed and he did not cut</p>						

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	<p>his foods into bite sized pieces. The DRS indicated client #1 did not have Dysphagia and should not have had a Dysphagia plan, instead client #1 should have had a choking risk plan. The DRS indicated client #1's identified dining needs were not clearly identified by the nursing services and/or the facility nurse upon admission and until client #1's 1/9/13 choking incident was investigated.</p> <p>9-3-6(a)</p>			

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W000391	<p>483.460(m)(2)(ii) DRUG LABELING</p> <p>The facility must remove from use drug containers with worn, illegible, or missing labels.</p> <p>Based on observation, record review, and interview, for 4 of 36 doses of medications observed administered at the morning and evening medication administrations (clients #1, #4, #5, and #8), the facility failed to ensure each medication was labeled.</p> <p>Findings include:</p> <p>1. On 11/12/13 at 4:16pm, GHS (Group Home Staff) #1 selected and administered from an unlabeled medication bottle of "Systane Solution (for dry eyes)" and placed one drop of the medication into each of client #1's eyes. At 4:24pm, GHS #1 indicated the medication bottle did not have client #1's name, a pharmacy label for the directions of its use, and/or did not document the date the bottle was opened. At 4:24pm, client #1's 11/2013 MAR (Medication Administration record) was reviewed and indicated "Systane Solution, instill 1 drop into each eye 4 x's a day (two times a day)."</p> <p>On 11/13/13 at 10:50am, client #1's 10/31/13 "Physician's Order" indicated "Systane Solution instill 1 drop into each eye 4 times a day" for dry eyes.</p>	W000391	<p>1. Extralabel obtained from pharmacy for eye drops. The box that the eye dropper comes in is clearly labeled from the pharmacy with the appropriate information, however, the small dropper bottle is not. The extra label will be placed on a zip lock bag and both the box and the dropper will be placed inside the bag to avoid issue should the dropper become separated from the box.</p> <p>2. Extralabel obtained from pharmacy for nose spray. The box that the nose spray comes in is clearly labeled from the pharmacy with the appropriate information, however the nasal spray is not. The extra label will be placed on a zip lock bag and both the box and the spray will be placed inside the bag to avoid issue should the dropper become separated from the box.</p> <p>3. Extralabel obtained from pharmacy for ointment. The box that the ointment comes in is clearly labeled from the pharmacy with the appropriate information, however the tube is not. The extra label will be placed on a zip lock bag and both the box and the ointment will be placed inside the bag to avoid issue should the tube become separated from the box.</p> <p>4. The MAR and the label on</p>	12/22/2013			

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	<p>2. On 11/13/13 at 7:55am, GHS #1 selected and administered from an unlabeled medication bottle of "Fluticasone 0.05% nasal spray" for nasal congestion and placed two (2) sprays into each of client #4's nostrils. At 8:00am, GHS #1 indicated the medication bottle did not have client #4's name, a pharmacy label for the directions of its use, and/or did not document the date the bottle was opened. At 8:00am, client #4's 11/2013 MAR was reviewed and indicated "Fluticasone 0.05% nasal spray, inhale 2 puffs in each nostril daily."</p> <p>On 11/14/13 at 11:10am, client #4's 10/31/13 "Physician's Order" indicated "Fluticasone 0.05% nasal spray, inhale 2 puffs in each nostril daily" for nasal congestion.</p> <p>3. On 11/12/13 at 3:46pm, GHS #1 selected and administered from an unlabeled tube of "Triple Antibiotic Ointment" and applied the ointment to each of client #5's fingers which had cuts and scrapes on each finger. At 4:00pm, GHS #1 indicated the Triple Antibiotic Ointment tube did not have client #5's name, a pharmacy label for the directions of its use, and/or did not document the date the bottle was opened. At 4:00pm, client #5's 11/2013 MAR was reviewed</p>		<p>the ear drops have been corrected to match the physician's orders. All staff will be retrained on 12/19/13 on medication administration policy which indicates that all medications can only be administered from pharmacy approved storage containers or packages with appropriate labeling that includes the name of the medication, the dosage, the route, the dates and times for administration and the date of expiration. To monitor for continued compliance, the Residential nurse or the Residential House Manager is required to review all medications for appropriate labeling and expiration dates. This will be documented on Appendix T and will be monitored as part of the monthly Periodic Service Review.</p>				

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	<p>and indicated "Triple Antibiotic Ointment, apply to fingers three times a day as needed" for cuts and scrapes.</p> <p>On 11/13/13 at 7:15am, GHS #1 selected and administered from an unlabeled tube of "Triple Antibiotic Ointment" and applied the ointment to each of client #5's fingers which had cuts and scrapes on each finger. At 7:16am, GHS #1 indicated the Triple Antibiotic Ointment tube did not have client #5's name, a pharmacy label for the directions of its use, and/or did not document the date the bottle was opened. At 7:16am, client #5's 11/2013 MAR was reviewed and indicated "Triple Antibiotic Ointment, apply to fingers three times a day as needed" for cuts and scrapes.</p> <p>On 11/13/13 at 10:25am, client #5's 10/31/13 "Physician's Order" indicated "Triple Antibiotic Ointment, apply to fingers three times a day as needed" for cuts and scrapes.</p> <p>4. On 11/12/13 at 4:05pm, GHS #1 selected and administered five (5) drops into each of client #8's ears from client #8's labeled medication bottle of "Carbamide 6.5% OT (Otic) solution, instill 4 drops into each ear at bedtime" for ear wax and ear pain. At 4:16pm, GHS #1 indicated client #8's</p>						

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	<p>Carbamoxide label did not match client #8's 11/2013 MAR. GHS #1 indicated client #8's Carbamoxide medication did not indicate when the bottle was opened for use. At 4:16pm, client #8's 11/2013 MAR indicated "Carbamide 6.5% OT (Otic) solution, instill 5 drops into each ear three times a day" for ear wax and ear pain.</p> <p>On 11/13/13 at 7:16am, GHS #1 selected and administered five (5) drops into each of client #8's ears from client #8's labeled medication bottle of "Carbamide 6.5% OT (Otic) solution, instill 4 drops into each ear at bedtime" for ear wax and ear pain. At 7:25am, GHS #1 indicated client #8's Carbamoxide label did not match client #8's 11/2013 MAR. GHS #1 indicated client #8's Carbamoxide medication did not indicate when the bottle was opened for use. At 7:25am, client #8's 11/2013 MAR indicated "Carbamide 6.5% OT (Otic) solution, instill 5 drops into each ear three times a day" for ear wax and ear pain.</p> <p>On 11/13/13 at 10:20am, client #8's 10/31/13 "Physician's Order" indicated "Carbamide 6.5% OT (Otic) solution, instill 5 drops into each ear three times a day" for ear wax and ear pain.</p> <p>On 11/13/13 at 10:30am, an interview</p>						

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	<p>with the agency RN (Registered Nurse) was conducted. The RN indicated the agency staff followed the "Living in the Community: Core A/Core B" medication training. The RN stated "All medications should be labeled with a pharmacy label." The RN indicated the facility staff should have dated each medication when the bottle was opened to document an open date of use. The RN indicated the nurse was responsible to make the changes on each medication label when a physician had changed the client's order to ensure each medication label matched each client's MAR and physician's order. The RN indicated she was not aware client #8's medicated ear drops did not match. The RN indicated client #1, #4, #5, and #8's medications were not labeled correctly. The RN indicated each medication should have client identification on each medication to signify it belonged to that client, a direction for the medication use, and open date if not replaced every thirty days.</p> <p>On 11/13/13 at 9:50am, a review of the 2004 "Living in the Community" medication administration training manual, Core Lesson 2: Responsibilities in the Area of Medication Administration indicated medications should be labeled. The training manual indicated each clients' medication should be dated when</p>			

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	<p>the medication was opened.</p> <p>On 11/13/13 at 9:50am, a review of the facility's undated "Medication Administration Plan" indicated "Medications can only be administered from pharmacy approved storage containers or packages with appropriate labeling that includes the name of the medication, the dosage, the route of administration, the dates and times for administration and the date of expiration...Staff shall refer to the Medication Administration Record (MAR) and compare to the packaged medication to verify the medication, the time of administration, and the correct dosage."</p> <p>9-3-6(a)</p>						