

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G744	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/31/2015
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NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2453 S 100 E PERU, IN 46970
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W 0000 Bldg. 00	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: 7/28, 7/29, 7/30, and 7/31/2015.</p> <p>Facility Number: 006630 Provider Number: 15G744 AIMS Number: 200902110</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0192 Bldg. 00	<p>483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>Based on observation, record review, and interview, for 1 of 4 sampled clients (client #3), the facility failed to ensure group home staff were competent to administer medications according to facility policy/procedure and Core A/Core B Medication Training for client #3's medication administration on 7/28/15.</p> <p>Findings include:</p>	W 0192	<p>To ensure that all medications are accurately administered by staff as outlined in Core A/Core B Medication Training regulations, the following corrective action(s) will be implemented:</p> <p>1) All staff located at 2453 South 100 East (Bobtail group home) will receive re-training on the Core A and Core B</p>	08/30/2015

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

TITLE

(X6) DATE

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

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	<p>On 7/28/15 at 1:50pm, GHS (Group Home Staff) #2 assembled client #3's Baclofen 10mg (milligrams) 1/2 tablet three times a day for body spasms and Diazepam 2mg, 1 tablet three times a day for spasms related to Cerebral Palsy into a medication cup. GHS #2 poured the medication tablets into pudding and stirred. GHS #2 took the medicated pudding into client #3's bedroom, woke client #3 up from his bed, and client #3 refused to open his mouth or consume the medicated pudding. GHS #2 returned the medicated pudding to the medication room and locked the medication up. At 2:00pm, GHS #2 asked Residential Manager (RM) #2 to administer client #3's medicated pudding. At 2:00pm, RM #2 unlocked the medication room, retrieved the open pudding with a spoon in the container, walked to client #3's room, and client #3 refused the medication. RM #2 returned the container to the medication room and secured the medication, went to client #3's bedroom, assisted client #3 to wake up, sit in a wheel chair, and RM #2 brought client #3 to the medication room. At 2:15pm, RM #2 administered client #3's medicated pudding; GHS #2 was not within eye sight of observing the medication being administered. At 2:15pm, RM #2 indicated she did not know what medications were contained</p>		<p>medication training. Additionally eachstaff will be required to complete competency exams following both trainingsessions to ensure a passing score of 85%. Completed Record of Trainings willbe obtained and submitted upon completion of training. <i>Refer to Appendixes A and B for Record of Training forms to be used.</i> It is the intent that this training will ensure competent medicationadministration by staff and prevent future medication errors for the clientsaffected as well as all other clients residing in the home.</p> <p>2) Toconsistently monitor medication administration and to ensure competency andcompliance,all Residential Nurses will be required to conduct weeklyreviews of all medication records for all clients residing in the home. Additionally, they will observe staff on a routine basis to ensure that allmedications are administered according to physician's orders, agency policy,and Core A/Core B</p>	

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	<p>in client #3's medicated pudding. At 2:15pm, RM #2 signed client #3's 7/2015 MAR (Medication Administration Record) that she administered client #3's medication.</p> <p>On 7/29/15 at 12:00noon, an interview with RN (Registered Nurse) was conducted. The RN indicated staff should follow Core A/Core B Living in the Community medication administration training when administering medications. The RN indicated staff did not follow the medication administration policy and procedure when the same staff did not administer client #3's medications after she had dispensed the medications into the pudding. The RN indicated the staff did not demonstrate competency for medication administration on 7/28/15.</p> <p>On 7/30/15 at 12:30pm, an interview was conducted with the RN. The RN stated she was "retraining the entire staff" at the group home on Core A/Core B Medication Administration because of the medication errors, failing to follow physician's orders, and failing to ensure unlabeled and unprescribed medications were not administered to the clients living in the group home.</p> <p>On 7/29/15 at 11:50am, a review of the</p>		<p>Medication Training guidelines. In the event of a medication error, theResidential Nurse will immediately review all medication records for allclients residing in the home, not just those that are affected, to ensure thatno other medication errors have occurred, that staff fully comprehend andunderstand directives for medication administration as stated on the MAR(medication administration record), and that medications are being administeredaccording to physician's orders and agency policy. The staff responsible forthe medication error will be counseled per agency policy and be re-trained onmedication administration.</p>		

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W 0227 Bldg. 00	<p>Core A/Core B Living in the Community Medication Training 4/2011 indicated the same staff who dispensed the medication should administer the medication and/or observe another staff to administer the medication. The medication training indicated before passing medications all staff will complete the Core A and Core B Medication Administration Curriculum which includes but is not limited to the following information: "All staff adhere" to the six rights of medication administration, "Read the label 3 times before med is poured," after med is poured and before med is given. The training indicated the staff should "notify the nurse if there is a label concern."</p> <p>9-3-3(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review, and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4), the facility failed to develop a program to address client #1, #2, and #3's identified incontinence needs at night and client #3 and #4's recommendations for an individualized system to communicate.</p>	W 0227	<p>To ensure that individual plans for clients #1, #2, #3, & #4 meet and address all identified needs, the following corrective action(s) will be implemented:</p> <p>1) The Qualified Intellectual Disabilities Professional</p>	08/30/2015

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	<p>Findings include:</p> <p>On 7/28/15 from 1:05pm until 3:00pm, on 7/28/15 from 3:15pm until 5:15pm, and on 7/29/15 from 5:40am until 8:05am, clients #1, #2, and #3 were assisted and prompted to use the facility bathroom and were changed by the facility staff during each observation period. During the observation periods client #3 was not prompted or encouraged to use pictures or cards to communicate his wants/needs. During the observation periods client #4 was not prompted or encouraged to use a Big Mac switch to communicate. During the observation periods clients #3 and #4 were non verbal.</p> <p>On 7/29/15 from 5:40am until 7:20am, client #3 sat at the dining room table. At 7:20am, client #3 was assisted by the facility staff to walk to his bedroom to have his brief changed after being incontinent. At 5:40am, GHS (Group Home Staff) #7 indicated client #3's bedding was urine soaked from his night time incontinence and carried client #3's urine soaked linen to the washer. At 6:30am, GHS #8 indicated client #2 was incontinent of urine during the night time hours and GHS #8 carried his urine soaked linen to the washer. At 6:30am,</p>		<p>(QIDP) will revise individual specific plans to address issues of incontinence for clients #1, #2, and #3. The revised plans will include level or degree of incontinence (i.e all day, nighttime only, etc), the goals and plans to address the incontinence, and system to monitor instances of incontinence to ensure that any changes are noted and addressed. Upon completion of the revised individual specific plans, the QIDP will train all staff working in the home to ensure knowledge of changes to the individual specific plans. When staff have finalized trainings they will complete an agency Record of Training form to indicate completion of the training and knowledge of the revisions to the individual specific plans. The QIDP will continue to revise plans as changes to the condition occur. As plans are updated, the QIDP will follow the training process as stated above.</p> <p>2) The QIDP will review and revise individual plans and goals regarding</p>		

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	<p>GHS #8 indicated clients #1, #2, and #3 were incontinent of urine during the night time hours and clients #1, #2, and #3 did not have goals and/or schedules to address their night time incontinence available for review. At 7:00am, GHS #5 and the RM (Residential Manager) entered client #1's bedroom to wake him. Both staff indicated client #1's adult brief and linens on client #1's bed were urine soaked from client #1's night time incontinence. At 7:00am, the RM indicated clients #1, #2, and #3 were incontinent of urine at night and no goals/objectives and/or schedules for night time toileting was available for review.</p> <p>Client #1's record was reviewed on 7/30/15 at 9:20am. Client #1's 2/25/15 ISP (Individual Support Plan) did not indicate a toileting goal and did indicate client #1 was to change his clothing when soiled. Client #1's 2/25/15 ISP did not include an objective to address his incontinence of bowel and/or bladder at night. Client #1's ISP did not indicate he was incontinent and wore adult briefs at night. Client #1's record did not indicate evidence of training to address client #1's incontinence. Client #1's record indicated he could use the toilet during the day independently.</p>		<p>communicationneeds and systems for clients #3 and #4. The revisions to each respective individualplan will include communication needs, methods of communication and anyadaptive equipment to be used. Additionally, the QIDP will ensure that anyadaptive equipment will meet the client's needs, be available for use, andstaff competency on equipment. Upon completion of the revised individualspecific plans, the QIDP will train all staff working in the home to ensure knowledgeof changes to the individual specific plans. When staff have finalizedtrainings they will complete an agency Record of Training form to indicatecompletion of the training and knowledge of the revisions to the individualspecific plans. The QIDP will continue to revise plans as changes to thecondition occur. As plans are updated, the QIDP will follow the trainingprocess as stated above.</p>	

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	<p>Client #2's record was reviewed on 7/30/15 at 11:35am. Client #2's 7/24/14 ISP (Individual Support Plan) did not include a toileting goal/objective to address his incontinence of bowel and/or bladder at night. Client #2's ISP did not indicate he was incontinent and wore adult briefs at night. Client #2's record did not indicate evidence of training to address client #2's incontinence.</p> <p>Client #3's record was reviewed on at 7/30/15 at 12:30pm. Client #3's 5/18/15 ISP and 5/2015 BSP (Behavior Support Plan) indicated a toileting goal to sit on the toilet. Client #3's ISP did not include an objective to address his incontinence of bowel and/or bladder at night. Client #3's ISP did not indicate he was incontinent and wore adult briefs at night. Client #3's record did not indicate evidence of training to address client #3's incontinence. Client #3's ISP indicated client #3 was non verbal and used gestures and noises to communicate. Client #3's 5/2015 BSP indicated staff were to use pictures and/or picture cards to communicate with client #3 to interrupt his behaviors and offer client #3 choices of activities.</p> <p>Client #4's record was reviewed on 7/30/15 at 10:30am. Client #4's 7/24/14 ISP indicated he was non verbal and</p>			

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	<p>indicated to indicate "no" by pushing away items not wanted. Client #4's 3/11/2009 Speech Therapy (ST) evaluation indicated a recommendation for client #4 to use a Big Mac switch to communicate "yes/no" answers to questions to communicate.</p> <p>On 7/31/15 at 2:40pm, an interview with the Residential Services Director (RSD) and the Vice President of Residential Services was conducted. The RSD indicated clients #1, #2, and #3 were incontinent of bowel and bladder during the night time hours and the clients did not have a schedule or goal available for review. The RSD indicated the facility staff were to use pictures and/or picture cards to communicate and no communication devices were available for client #3. The RSD indicated client #4 had a recommendation for the use of a Big Mac switch to communicate his wants/needs and she did not know the action taken for that recommendation. The RSD indicated no further information was available for review.</p> <p>9-3-4(a)</p>						
W 0240 Bldg. 00	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the						

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	<p>individual toward independence.</p> <p>Based on observation, record review, and interview, for 2 of 4 sampled clients (clients #2 and #3), the facility failed to ensure client #2 and #3's ISPs (Individual Support Plans) indicated when and/or described interventions to promote independence regarding when client #2 should use his bedroom floor pad alarm and when client #3 was to use his bedroom door alarm, divided plate, curved adaptive spoon, and wheel chair.</p> <p>Findings include:</p> <p>On 7/28/15 from 1:05pm until 3:00pm, on 7/28/15 from 3:15pm until 5:15pm, and on 7/29/15 from 5:40am until 8:05am, client #2 had an alarm pad on the floor of his bedroom and client #3 had a door alarm on his bedroom door.</p> <p>On 7/28/15 at 1:35pm, GHS (Group Home Staff) #2 stated client #2's floor pad alarm was because client #2 had the behaviors of getting up without staff during the day and night time hours. GHS #2 indicated client #2 had the alarm to alert staff client #2 was up out of bed. At 1:35pm, GHS #2 indicated client #3 had an alarm on client #3's bedroom door to alert staff when client #3 exited his bedroom because client #3 had eloped from the facility and had physically aggressive behaviors towards others. On</p>	W 0240	<p>To ensure that individual plans for clients #2 and #3, meet and address all identified needs, the following corrective action(s) will be implemented:</p> <p>1) The Qualified Intellectual Disabilities Professional (QIDP) will revise individual specific plans and behavior support plans to address individual and behavioral needs. Additionally, the QIDP will create goals for each client to strive for independence with staff assistance while working on identified needs. The revised plans will include the purpose and use of restrictive or adaptive equipment such as alarms, serving ware and utensils, etc. Before implementing such plans, the QIDP will gain approval from the agency Human Rights Committee (HRC) to ensure protection of client rights. Upon completion of the revised individual specific plans, the QIDP will train all staff working in the home to ensure knowledge of changes to the individual</p>	08/30/2015

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	<p>7/28/15 from 1:05pm until 3:00pm, client #3 used a wheel chair and was moved throughout the group home by the facility staff. From 3:15pm until 5:15pm, client #3 sat in a recliner, laid on the sofa, and sat crossed legged in a dining room chair. On 7/28/15 from 4:45pm until 5:15pm, client #3 fed himself dinner and did not use a curved adaptive spoon and did not use a divided plate.</p> <p>On 7/29/15 at 7:04am, GHS #7 mixed client #3's foods onto a white divided plate which was chipped in three (3) places, a curved adaptive spoon, and gave the chipped plate with food to client #3 to eat. From 7:04am until 7:20am, client #3 fed himself his breakfast with the curved adaptive spoon from the chipped divided plate.</p> <p>Client #2's record was reviewed on 7/30/15 at 11:35am. Client #2's 7/24/14 ISP (Individual Support Plan) did not include the use of the bedroom floor pad alarm and no Behavior Support Plan was available for review.</p> <p>Client #3's record was reviewed on 7/30/15 at 12:30pm. Client #3's 5/18/15 ISP and 5/2015 BSP (Behavior Support Plan) did not indicate the use of his bedroom door alarms for behaviors, the divided plate, the curved adaptive spoon,</p>		<p>specific plans. When staff have finalized training they will complete an agency Record of Training form to indicate completion of the training and knowledge of the revisions to the individual specific plans. The QIDP will continue to revise plans as changes to the condition occur. As plans are updated, the QIDP will follow the training process as stated above.</p>				

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W 0289 Bldg. 00	<p>and the wheelchair.</p> <p>On 7/31/15 at 2:40pm, an interview with the Residential Services Director (RSD) and the Vice President of Residential Services was conducted. The RSD indicated client #2's ISP did not include the use of his bedroom floor pad alarm. The RSD indicated client #3's plans did not include the use of his bedroom door alarm, divided plate, curved adaptive spoon, and wheelchair.</p> <p>9-3-4(a)</p> <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 observation, record review, and interview, for 2 of 3 sampled clients (clients #2 and #3) who had physical interventions employed for behavior, the facility failed to have a written description in client #2's plan for his bedroom floor pad alarm and client #3's bedroom door alarm used for behaviors.</p> <p>Findings include:</p> <p>On 7/28/15 from 1:05pm until 3:00pm,</p>	W 0289	<p>Toensure that individual plans for clients #2 and #3, meet and address allidentified needs, the following corrective action(s) will be implemented:</p> <p>1) TheQualified Intellectual Disabilities Professional (QIDP) will revise behaviorsupport plans(BSP) to address individual and behavioral needs.</p>	08/30/2015

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	<p>on 7/28/15 from 3:15pm until 5:15pm, and on 7/29/15 from 5:40am until 8:05am, client #2 had an alarm pad on the floor of his bedroom and client #3 had a door alarm on his bedroom door. On 7/28/15 at 1:35pm, GHS (Group Home Staff) #2 stated client #2's floor pad alarm was because client #2 had the behaviors of getting up without staff during the day and night time hours. GHS #2 indicated client #2 had the alarm to alert staff client #2 was up out of bed. At 1:35pm, GHS #2 indicated client #3 had an alarm on client #3's bedroom door to alert staff when client #3 exited his bedroom because client #3 had eloped from the facility and had physically aggressive behaviors towards others.</p> <p>Client #2's record was reviewed on 7/30/15 at 11:35am. Client #2's 7/24/14 ISP (Individual Support Plan) did not include the use of the bedroom floor pad alarm and no Behavior Support Plan was available for review. Client #2's record did not include the use of the bedside floor pad alarm. Client #2's record included HRC (Human Rights Committee) consents for 7/8/15 and 2/23/15 for the use and review of the floor pad alarms as a client's rights restriction.</p> <p>Client #3's record was reviewed on at</p>		<p>Additionally, the QIDP will create goals for each client to strive for independence with staff assistance while working on identified needs. The revised plans will include the purpose and use of restrictive or adaptive equipment such as alarms, serving ware and utensils, etc. Before implementing such plans, the QIDP will gain approval from the agency Human Rights Committee (HRC) to ensure protection of client rights. Upon completion of the revised behavioral support plan (BSP), the QIDP will train all staff working in the home to ensure knowledge of changes to the individual specific plans. When staff have finalized trainings they will complete an agency Record of Training form to indicate completion of the training and knowledge of the revisions to the individual specific plans. The QIDP will continue to revise plans as changes to the condition occur. As plans are updated, the QIDP will</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G744		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/31/2015	
NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2453 S 100 E PERU, IN 46970			
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W 0331 Bldg. 00	<p>7/30/15 at 12:30pm. Client #3's 5/18/15 ISP and 5/2015 BSP (Behavior Support Plan) did not indicate the use of his bedroom door alarms for behaviors.</p> <p>On 7/31/15 at 2:40pm, an interview with the Residential Services Director (RSD) and the Vice President of Residential Services was conducted. The RSD indicated client #2 had a bedside floor pad alarm to alert staff when client #2 got out of bed and client #3 had a bedroom door alarm to alert staff when client #3 left his bedroom. The RSD indicated clients #2 and #3 did not recognize danger and required twenty-four hour staff supervision. The RSD indicated client #2 and #3's ISP, BSP, and risk plans should have included client #2's bedside floor pad alarm and client #3's bedroom door alarm.</p> <p>9-3-5(a)</p> <p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review, and interview, for 2 of 4 sampled clients (clients #2 and #3), the facility's nursing staff failed to provide nursing oversight to ensure medications were administered according to physician's orders.</p>			W 0331	<p>follow the training process as stated above.</p> <p>To ensure that all medications are accurately administered by staff as directed by physician's orders, the following corrective action(s) will be</p>		08/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G744	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/31/2015
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NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2453 S 100 E PERU, IN 46970
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	<p>Findings include:</p> <p>1. Client #2's record was reviewed on 7/30/15 at 11:30am. Client #2's 5/22/15 "Nurses Notes" indicated client #2 was to have had his "Tegretol 100mg (milligrams) for seizures, take 1/2 (one half) tablet by mouth daily" discontinued on 5/1/15 and client #2 continued to receive the Tegretol medication until 5/22/2015. Client #2's 5/2015 MAR (Medication Administration Record) indicated client #2 received the Tegretol medication from 5/1/15 and the last dose administered was on 5/22/15. Client #2's 3/24/15 Physician's Order indicated "Doing very well. Stop Tegretol (medication) on 5/1/15" signed by client #2's Physician. Client #2's 5/28/15 Nursing Quarterly assessment did not indicate client #2's Tegretol had been discontinued by his physician.</p> <p>On 7/29/15 at 12:00noon, an interview with RN (Registered Nurse) was conducted. The RN indicated staff should administer medications according to physician's orders. The RN indicated staff did not follow the medication administration policy and procedure when medications were administered and client #2's physician's orders were not followed for stopping client #2's Tegretol</p>		<p>implemented:</p> <p>1) Toconsistently monitor medication administration and to ensure competency andcompliance,all Residential Nurses will be required to conduct weeklyreviews of all medication records for all clients residing in the home.Additionally, they will observe staff on a routine basis to ensure that allmedications are administered according to physician's orders, agency policy,and Core A/Core B Medication Training guidelines. In the event of a medication error, theResidential Nurse will immediately review all medication records for allelients residing in the home, not just those that are affected, to ensure thatno other medication errors have occurred, that staff fully comprehend andunderstand directives for medication administration as stated on the MAR(medication administration record), and that medications are being administeredaccording to</p>	

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	<p>on 5/1/15. The RN indicated staff should follow Core A/Core B Living in the Community medication administration training when administering medications. The RN stated "We missed it."</p> <p>2. On 7/29/15 at 7:30am, GHS (Group Home Staff) #7 and client #3 who was seated in a wheel chair went into the shower room. GHS #7 retrieved from the medication room an unlabeled bottle of "Wound 1st Aid Spray" and a Band-Aid. GHS #7 walked into the shower room where client #3 sat barefoot, applied the "Wound 1st Aid Spray" to client #3's right big toe where the skin was cracked open, shiny with moisture, and was a bright red color. GHS #7 then covered the open area on client #3's big toe with a Band-Aid. At 7:55am, GHS #5 indicated the "Wound 1st Aid Spray" bottle was unlabeled, did not have directions for its use, and the medication was administered on client #3's toe. At 7:55am, GHS #5 indicated the "Wound 1st Aid Spray" was not documented as administered in client #3's 7/2015 MAR or his record.</p> <p>Client #3's record was reviewed on 7/30/15 at 12:30pm. Client #3's 6/11/15 Physician's Order did not include the use of the "Wound 1st Aid Spray." Client #3's 7/2015 MAR (Medication Administration Record) did not indicate</p>		<p>physician's orders and agency policy. The staff responsible for the medication error will be counseled per agency policy and be re-trained on medication administration.</p>				

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	<p>client #3 had "Wound 1st Aid Spray" applied to his open area on his big toe on 7/29/15.</p> <p>On 7/29/15 at 12:00noon, an interview with RN (Registered Nurse) was conducted. The RN indicated staff should administer medications according to physician's orders. The RN indicated staff did not follow the medication administration policy and procedure when medications were administered and client #3's physician's orders were not followed. The RN indicated client #3's physician had not ordered the "Wound 1st Aid Spray" and the spray should not have been used on client #3's open area on his toe. The RN indicated staff should follow Core A/Core B Living in the Community medication administration training when administering medications. The RN indicated medications should be labeled with a pharmacy label, the clients' name, and the directions for the medication's use. The RN indicated the "Wound 1st Aid Spray" was not labeled.</p> <p>On 7/29/15 at 11:50am, a review of the Core A/Core B Living in the Community Medication Training 4/2011 indicated staff should administer client medications according to physician's orders. The medication training indicated before passing medications all staff will</p>			

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	<p>complete the Core A and Core B Medication Administration Curriculum which includes but is not limited to the following information: "All staff adhere" to the six rights of medication administration, "Read the label 3 times before med is poured," after med is poured and before med is given. The training indicated "General Considerations to Remember when Administering Medications: Never administer a medication from an unlabeled or illegibly labeled container. Notify the nurse if there is a label concern...."</p> <p>3. On 7/28/15 at 1:50pm, GHS (Group Home Staff) #2 assembled client #3's Baclofen 10mg (milligrams) 1/2 tablet three times a day for body spasms and Diazepam 2mg, 1 tablet three times a day for spasms related to Cerebral Palsy into a medication cup. GHS #2 then poured the medication tablets into pudding. GHS #2 took the medicated pudding into client #3's bedroom, woke client #3 up from his bed, and client #3 refused to open his mouth or consume the medicated pudding. GHS #2 returned the medicated pudding to the medication room and locked the medication up. At 2:00pm, GHS #2 asked Residential Manager (RM) #2 to administer client #3's medicated pudding. At 2:00pm, RM</p>			

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	<p>#2 unlocked the medication room, retrieved the open pudding with a spoon in the container, walked to client #3's room, and client #3 refused the medication. RM #2 returned the container to the medication room and secured the medication, went to client #3's bedroom, assisted client #3 to wake up, sit in a wheel chair, and RM #2 brought client #3 to the medication room. At 2:15pm, RM #2 administered client #3's medicated pudding; GHS #2 was not within eye sight of observing the medication being administered. At 2:15pm, RM #2 indicated she did not know what medications were contained in client #3's medicated pudding. At 2:15pm, RM #2 signed client #3's 7/2015 MAR (Medication Administration Record) that she administered client #3's medication.</p> <p>On 7/29/15 at 12:00noon, an interview with RN (Registered Nurse) was conducted. The RN indicated staff should follow Core A/Core B Living in the Community medication administration training when administering medications. The RN indicated staff did not follow the medication administration policy and procedure when the same staff did not administer client #3's medications after she had dispensed the medications into</p>			

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	<p>the pudding. The RN indicated the staff did not demonstrate competency for medication administration on 7/28/15.</p> <p>On 7/30/15 at 12:30pm, an interview was conducted with the RN. The RN stated she was "retraining the entire staff" at the group home on Core A/Core B Medication Administration because of the medication errors, failing to follow physician's orders, and failing to ensure unlabeled and unprescribed medications were not administered to the clients living in the group home.</p> <p>On 7/29/15 at 11:50am, a review of the Core A/Core B Living in the Community Medication Training 4/2011 indicated the same staff who dispensed the medication should administer the medication and/or observe another staff to administer the medication. The medication training indicated before passing medications all staff will complete the Core A and Core B Medication Administration Curriculum which includes but is not limited to the following information: "All staff adhere" to the six rights of medication administration, "Read the label 3 times before med is poured," after med is poured and before med is given. The training indicated the staff should "notify the nurse if there is a label concern."</p>			

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W 0368 Bldg. 00	<p>9-3-6(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on observation, record review, and interview, for 2 of 4 sampled clients (clients #2 and #3), the facility failed to administer medications without error and as prescribed by client #2 and #3's physician.</p> <p>Findings include:</p> <p>1. On 7/29/15 at 9:20am, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 5/1/2015 through 7/29/15 were reviewed and did not include the following medication error for client #2:</p> <p>Client #2's record was reviewed on 7/30/15 at 11:30am. Client #2's 5/22/15 "Nurses Notes" indicated client #2 was to have had his "Tegretol 100mg (milligrams) for seizures, take 1/2 (one half) tablet by mouth daily" discontinued on 5/1/15 and client #2 continued to receive the Tegretol medication until 5/22/2015. Client #2's 5/2015 MAR (Medication Administration Record) indicated client #2 received the Tegretol</p>	W 0368	<p>Toensure that all medications are accurately administered by staff as directed byphysician's orders, the following corrective action(s) will be implemented:</p> <p>1) Allstaff located at 2453 South 100 East (Bobtail group home) will receive re-training on the Core A and Core B medication training. Additionally will berequired to complete competency exams following both training sessions toensure a passing score of 85%. Completed Record of Trainings will be obtainedand submitted upon completion of training. <i>Refer to Appendixes A and B for Record of Training forms to be used.</i> It is the intent that this training will ensure competent medicationadministration by staff and prevent future medication errors for the</p>	08/30/2015

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	<p>medication from 5/1/15 and the last dose administered was on 5/22/15. Client #2's 3/24/15 Physician's Order indicated "Doing very well. Stop Tegretol (medication) on 5/1/15" signed by client #2's Physician. Client #2's 5/28/15 Nursing Quarterly assessment did not indicate client #2's Tegretol had been discontinued by his physician.</p> <p>On 7/29/15 at 12:00noon, an interview with RN (Registered Nurse) was conducted. The RN indicated staff should administer medications according to physician's orders. The RN indicated staff did not follow the medication administration policy and procedure when medications were administered and client #2's physician's orders were not followed for stopping client #2's Tegretol on 5/1/15. The RN indicated staff should follow Core A/Core B Living in the Community medication administration training when administering medications. The RN stated "We missed it."</p> <p>2. On 7/29/15 at 7:30am, GHS (Group Home Staff) #7 and client #3 seated in a wheel chair went into the shower room. GHS #7 retrieved from the medication room an unlabeled bottle of "Wound 1st Aid Spray" and a Band-Aid. GHS #7 walked into the shower room where client #3 sat barefoot, applied the</p>		<p>clientsaffected as well as all other clients residing in the home.</p> <p>2) Toconsistently monitor medication administration and to ensure competency andcompliance,all Residential Nurses will be required to conduct weeklyreviews of all medication records for all clients residing in the home.Additionally, they will observe staff on a routine basis to ensure that allmedications are administered according to physician's orders, agency policy,and Core A/Core B Medication Training guidelines. In the event of a medication error, theResidential Nurse will immediately review all medication records for allclients residing in the home, not just those that are affected, to ensure thatno other medication errors have occurred, that staff fully comprehend andunderstand directives for medication administration as stated on the MAR(medication administration record), and that medications are being</p>				

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	<p>"Wound 1st Aid Spray" to client #3's right big toe where the skin was cracked open, shiny with moisture, and was a bright red color. GHS #7 then covered the open area on client #3's big toe with a Band-Aid.</p> <p>Client #3's record was reviewed on 7/30/15 at 12:30pm. Client #3's 6/11/15 Physician's Order did not include the use of the "Wound 1st Aid Spray." Client #3's 7/2015 MAR (Medication Administration Record) did not indicate client #3 had "Wound 1st Aid Spray" applied to his open area on his big toe.</p> <p>On 7/29/15 at 12:00noon, an interview with RN (Registered Nurse) was conducted. The RN indicated staff should administer medications according to physician's orders. The RN indicated staff did not follow the medication administration policy and procedure when medications were administered and client #3's physician's orders were not followed. The RN indicated client #3's physician had not ordered the "Wound 1st Aid Spray" and the spray should not have been used for client #3's open area on his toe. The RN indicated staff should follow Core A/Core B Living in the Community medication administration training when administering medications.</p>		administered according to physician's orders and agency policy. The staff responsible for the medication error will be counseled per agency policy and be re-trained on medication administration.		

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W 0391 Bldg. 00	<p>On 7/29/15 at 11:50am, a review of the Core A/Core B Living in the Community Medication Training 4/2011 indicated staff should administer client medications according to physician's orders.</p> <p>9-3-6(a)</p> <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 1 of 3 clients (client #3) who had medications observed administered during the morning medication administration, the facility failed to remove from use the medication containers without labels from the pharmacy on 7/29/15.</p> <p>Findings include:</p> <p>On 7/29/15 at 7:30am, GHS (Group Home Staff) #7 and client #3 seated in a wheel chair went into the shower room. GHS #7 retrieved from the medication room an unlabeled bottle of "Wound 1st Aid Spray" and a Band-Aid. GHS #7 walked into the shower room where client #3 sat barefoot, applied the "Wound 1st Aid Spray" to client #3's right big toe where the skin was cracked</p>	W 0391	<p>Toensure that all medications prescribed by a physician are labeled accordinglyfor use, the following corrective action(s) will be implemented:</p> <p>1) TheResidential Nurse will review medication labels and containers on a monthlybasis. During this time each nurse will be looking for medications that areexpired, labeled incorrectly or not labeled at all. If a medication is found tobe expired, labeled incorrectly, or missing a label, the Residential Nurse willremove the medication from the stored area and contact the prescribed physicianand/or pharmacy</p>	08/30/2015

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	<p>open, shiny with moisture, and was a bright red color. GHS #7 then covered the open area on client #3's big toe with a Band-Aid. At 7:55am, GHS #5 indicated the "Wound 1st Aid Spray" bottle was unlabeled, did not have directions for its use, and the medication was administered on client #3's toe.</p> <p>Client #3's record was reviewed on 7/30/15 at 12:30pm. Client #3's 6/11/15 Physician's Order did not include the use of the "Wound 1st Aid Spray." Client #3's 7/2015 MAR (Medication Administration Record) did not indicate client #3 had "Wound 1st Aid Spray" applied to his open area on his big toe on 7/29/15.</p> <p>On 7/29/15 at 12:00noon, an interview with RN (Registered Nurse) was conducted. The RN indicated staff did not follow the medication administration policy and procedure when medications were administered from an unlabeled bottle of medication. The RN indicated client #3's physician had not ordered the "Wound 1st Aid Spray" and the spray should not have been used on client #3's open area on his toe. The RN indicated staff should follow Core A/Core B Living in the Community medication administration training when administering medications. The RN</p>		<p>immediately to obtain current and correctly labeled medication for use.</p> <p>Additionally, all medications are reviewed on bi-monthly basis by the Residential Quality Assurance Coordinator to also screen for medications that are expired, labeled incorrectly or not labeled at all. If a medication is found to be expired, labeled incorrectly, or missing a label, the Residential Quality Assurance Coordinator will contact the Residential Nurse immediately so that the Nurse can obtain current and correctly labeled medication for use.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G744	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/31/2015
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NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2453 S 100 E PERU, IN 46970
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W 0436 Bldg. 00	<p>indicated medications should be labeled with a pharmacy label, the client's name, and the directions for the medication's use. The RN indicated the "Wound 1st Aid Spray" was not labeled.</p> <p>On 7/29/15 at 11:50am, a review of the Core A/Core B Living in the Community Medication Training 4/2011 indicated before passing medications all staff will complete the Core A and Core B Medication Administration Curriculum which includes but is not limited to the following information: "All staff adhere" to the six rights of medication administration, "Read the label 3 times before" the medication was administered. The training indicated "General Considerations to Remember when Administering Medications: Never administer a medication from an unlabeled or illegibly labeled container. Notify the nurse if there is a label concern...."</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary</p>			

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	<p>team as needed by the client.</p> <p>Based on observation, record review, and interview, for 1 of 4 sampled clients (client #3) with adaptive equipment, the facility failed to have available client #3's picture cards used to communicate and failed to keep his divided plate in good repair.</p> <p>Findings include:</p> <p>On 7/28/15 from 1:05pm until 3:00pm, on 7/28/15 from 3:15pm until 5:15pm, and on 7/29/15 from 5:40am until 8:05am, observations were completed with client #3 at the group home and client #3 was not prompted or encouraged to use pictures or cards to communicate his wants/needs. During the observation periods client #3 was non verbal.</p> <p>On 7/29/15 at 7:04am, GHS (Group Home Staff) #7 mixed client #3's foods onto a white divided plate which was chipped in three (3) places and gave the chipped plate with food to client #3 to eat. From 7:04am until 7:20am, client #3 fed himself his breakfast with the curved adaptive spoon from the chipped divided plate.</p> <p>Client #3's record was reviewed on at 7/30/15 at 12:30pm. Client #3's 5/18/15</p>	W 0436	<p>To ensure that all individual plans and adaptive equipment for client #3 meet and address all identified needs, the following corrective action(s) will be implemented:</p> <p>1) The QIDP will review and revise individual plans and goals regarding communication needs, systems, and adaptive equipment for client #3. The revisions will include communication needs, methods of communication and any adaptive equipment to be used. Additionally, the QIDP will ensure that any adaptive equipment will meet the client's needs, be available for use, and staff competency on equipment. Upon completion of the revised individual specific plans, the QIDP will train all staff working in the home to ensure knowledge of changes to the individual specific plans. When staff have finalized trainings they will complete an agency Record of Training form to indicate completion of the training and knowledge of</p>	08/30/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G744		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/31/2015	
NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2453 S 100 E PERU, IN 46970			
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W 0484 Bldg. 00	<p>ISP and 5/2015 BSP (Behavior Support Plan) indicated client #3 was non verbal and used gestures and noises to communicate. Client #3's 5/2015 BSP indicated staff were to use pictures and/or picture cards to communicate with client #3 to interrupt his behaviors and offer client #3 choices of activities.</p> <p>On 7/31/15 at 2:40pm, an interview with the Residential Services Director (RSD) and the Vice President of Residential Services was conducted. The RSD indicated client #3 was was non verbal and the facility staff were to use pictures and/or picture cards to communicate. The RSD indicated client #3's divided plate should not have been chipped. The RSD indicated no further information was available for review.</p> <p>9-3-7(a)</p> <p>483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.</p> <p>Based on observation and interview, for 2 of 4 sampled clients (clients #3 and #4), the facility failed to encourage client #4 for the use of utensils to eat and failed to provide client #3 a divided plate in good</p>			W 0484	<p>therevisions to the individual specific plans. The QIDP will continue to reviseplans as changes to the condition occur. As plans are updated, the QIDP willfollow the training process as stated above.</p> <p>Toensure that all clients are provided with proper serving and dining ware wheneating, the following corrective action(s) will be</p>		08/30/2015

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	<p>repair.</p> <p>Findings include:</p> <p>On 7/28/15 from 3:15pm until 5:15pm and on 7/29/15 from 5:40am until 8:05am, clients #3 and #4 were observed at the group home. On 7/29/15 at 6:10am, GHS (Group Home Staff) #8 selected waffles, cut the waffles into bite size pieces on a plate, squeezed syrup from a bottle onto each bite of waffle, and put the plate of cut up food in front of client #4 seated at the kitchen table. GHS #8 indicated client #4 was blind and verbally prompted client #4 to eat and no utensils or a napkin were provided. From 6:10am until 6:35am, client #4 moved his finger through the food on his plate and fed himself with his fingers the cut up waffles with syrup. No napkin and no utensils were taught and encouraged. At 7:04am, GHS #7 mixed client #3's foods onto a white divided plate which was chipped in three (3) places and gave the chipped plate with food to client #3 to eat. From 7:04am until 7:20am, client #3 fed himself his breakfast from a chipped divided plate.</p> <p>On 7/31/15 at 2:40pm, an interview with the Residential Services Director (RSD) and the Vice President of Residential Services was conducted. The RSD</p>		<p>implemented:</p> <p>To ensure that the clients are encouraged to practice independence during meal times as well as have all the necessary dining utensils and serving ware, all staff located at 2453 South 100 East (Bobtail group home) will be re-trained on family style dining. Additionally, during the training staff will be taught to examine adaptive dining equipment to ensure pieces are free from damages, chips, or missing pieces. Refer to <i>Appendix C for Record of Training form to be used to document training.</i></p>	

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NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2453 S 100 E PERU, IN 46970			
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W 9999 Bldg. 00	<p>indicated clients #3 and #4 received meals at the facility. The RSD indicated clients should be taught and encouraged to use utensils to eat with and plates in good repair should be available for use during dining opportunities.</p> <p>9-3-8(a)</p> <p>State Findings:</p> <p>460 IAC 9-3-1(b) The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p> <p>The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division (16b.) A medication error-wrong dosage given.</p> <p>This state rule is not met as evidence by:</p> <p>Based on record review and interview, for 1 of 4 sampled clients (client #2), the facility failed to report to the Bureau of Developmental Disabilities Services (BDDS) regarding the facility staff</p>	W 9999	<p>Toensure that established agency policies and procedures for incident reportings being implemented and executed as written, the following corrective action(s)will be implemented:</p> <p>1) All staff located at 2543 South 100East will be re-trained on the agency Personnel Policies and Procedures, PolicyIII:13: Incident Reporting. Completed Record of Trainings will be obtained andsubmitted upon completion of training. <i>Refer to Appendix D for Record of Trainingform to be used.</i></p>	08/30/2015			

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	<p>failing to discontinue client #2's medication as directed by client #2's physician.</p> <p>Findings include:</p> <p>On 7/29/15 at 9:20am, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 5/1/2015 through 7/29/15 were reviewed and did not include the following medication error for client #2:</p> <p>Client #2's record was reviewed on 7/30/15 at 11:30am. Client #2's 5/22/15 "Nurses Notes" indicated client #2 was to have had his "Tegretol 100mg (milligrams) for seizures, take 1/2 (one half) tablet by mouth daily" discontinued on 5/1/15 and client #2 continued to receive the Tegretol medication until 5/22/2015. Client #2's 5/2015 MAR (Medication Administration Record) indicated client #2 received the Tegretol medication from 5/1/15 and the last dose administered was on 5/22/15. Client #2's 3/24/15 Physician's Order indicated "Doing very well. Stop Tegretol (medication) on 5/1/15" signed by client #2's Physician. Client #2's 5/28/15 Nursing Quarterly assessment did not indicate client #2's Tegretol had been discontinued by his physician.</p>			

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	<p>On 7/31/15 at 2:40pm, an interview with the Residential Services Director (RSD) and the Vice President of Residential Services was conducted. The RSD indicated client #2's medication error from 5/1/15 through 5/22/15 was not reported to BDDS and no additional information was available for review.</p> <p>On 7/29/15 at 12:00noon, an interview with RN (Registered Nurse) was conducted. The RN indicated staff should administer medications according to physician's orders. The RN stated "We missed it." The RN indicated client #2's medication error/staff failing to discontinue client #2's Tegretol was not reported to BDDS.</p> <p>9-3-1(b)</p>			