

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G732	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/19/2015
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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1730 OSAGE DR KOKOMO, IN 46902
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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: 10/5, 10/6, 10/7, 10/8, 10/9, 10/13, 10/14, 10/15, 10/16, and 10/19/2015.</p> <p>Facility Number: 011266 Provider Number: 15G732 AIM Number: 200840950</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 10/27/15.</p>	W 0000		
W 0104  Bldg. 00	<p>483.410(a)(1) GOVERNING BODY 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 sampled clients (clients #1, #2, #3, and #4) and 4 additional clients (clients #5, #6, #7, and #8), the governing body failed to exercise operating direction over the facility to complete maintenance and repairs for clients #1, #2, #3, #4, #5, #6, #7, and #8's</p>	W 0104	<p><b>Toensure routine maintenance and proper operating direction over the group home,the following corrective action(s) will be implemented:</b></p> <p>1) TheDirector of Safety</p>	11/18/2015

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>group home.</p> <p>Findings include:</p> <p>On 10/5/15 from 4:00pm until 5:45pm and on 10/6/15 from 6:00am until 8:45am, observation and interview were completed at the group home with clients #1, #2, #3, #4, #5, #6, #7, and #8. Clients #1, #2, #3, #4, #5, #6, #7, and #8 walked into and out of each room using the living room and hallway of the group home. During both observation periods clients #1, #3, #4, and #5 sat on the living room floor carpet.</p> <p>On 10/6/15 at 6:20am, GHS (Group Home Staff) #2 and GHS #5 both stated the living room and hallway carpets had black "stains" and "were worn." The following areas were observed with GHS #2 and GHS #5:</p> <ul style="list-style-type: none"> <li>-The light colored living room carpet had a four feet by two feet (4' x 2') black stained and worn area in front of one sofa.</li> <li>-The light colored living room carpet had a three feet by two feet (3' x 2') black stained and worn area area in front of a second sofa.</li> <li>-The light colored hallway carpet had two black and worn areas. The first was two feet by two feet (2' x 2') and the second was four feet by two feet (4' x 2').</li> </ul>		<p>and Maintenance will survey the Group Home's carpets. She will secure bids to replace the carpet in the living room and the hallway. Once all bids have been obtained, the administrative team will determine the best course of action based on cost analysis and client needs.</p> <p>2) Residential house manager completes a weekly safety report that is for the purpose of reporting maintenance issues. The form was updated to include a section to report carpet stains and paint needs (Appendix A). This is sent to the Residential Director, Executive Vice President, and the Coordinator of Maintenance. Residential House Manager will be re-trained on completing the weekly safety reports. (Appendix B) All record of training's will be completed following staff training's and will be submitted to the Residential House Manager for administrative oversight.</p>	
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W 0129 Bldg. 00	<p>On 10/6/15 at 8:45am, the Residential Manager (RM) indicated the living room and hallway carpets were stained with black areas and were worn.</p> <p>On 10/16/15 at 2:45pm, an interview was conducted with the Director of Residential Services (DRS). The DRS indicated the group home carpet was in need of repairs and indicated she was not aware the carpet was stained and/or worn. The DRS indicated no further information was available for review.</p> <p>9-3-1(a)</p> <p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must provide each client with the opportunity for personal privacy.</p> <p>Based on observation, record review, and interview, for 2 of 4 sampled clients (clients #1 and #4) and 2 additional clients (clients #6 and #7), the facility failed to keep client #1, #4, #6, and #7's personal information confidential by posting each client's full names, work locations, group home addresses, and workshop schedules.</p> <p>Findings include:</p>	W 0129	<b>To ensure that all personal information is kept confidential in accordance to all HIPPA regulations while the clients are at their day service programming at the Bona Vista Workshop, the following corrective action(s) will be implemented:</b>	11/18/2015

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	<p>On 10/14/15 from 9:45am until 11:20am, clients #1, #4, #6, and #7 were observed at the facility owned day services. Visitors, other clients, family members, vendors, and workshop staff were observed to enter and exit the workshop area. At 10:40am, a posted sheet of paper included a list of clients #1, #4, #6, and #7's names who attended workshop. The sheet of paper indicated a 10/14/15 "Sign In / Sign Out Sheet" which indicated clients #1, #4, #6, and #7's full names, each client's group home address, the area of the workshop in which each client worked, and if the client was leaving the workshop area. At 10:50am, the Workshop Supervisor (WKS) was interviewed and indicated clients #1, #4, #6, and #7's personal information was not kept confidential when the information was posted on a reception table at the entrance/exit to the workshop for vendors, visitors, other clients, other staff, and families to review.</p> <p>On 10/16/15 at 2:45pm, an interview with the Director of Residential Services (DRS) was conducted. The DRS indicated clients #1, #4, #5, #6, and #7's personal information with their individual names should not have been posted at the facility entry/exit in full view of people leaving and entering the</p>		<p>1) Dayservice programming has eliminated all address, group home names, worklocations, and workshop schedules from the paperwork posted at the receptiontable. All clients are now being identified on the paperwork by their HIPPA names.</p>				

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W 0157 Bldg. 00	<p>workshop. The DRS indicated the group home staff failed to keep client #1, #4, #6, and #7's personal programming information confidential.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and for 3 additional clients (clients #5, #6, and #7), the facility failed to complete effective corrective action to address the continued client to client physical aggression for clients #1, #2, #3, #4, #5, #6, and #7 for 20 of 29 reportable incidents reviewed.</p> <p>Findings include:</p> <p>On 10/6/15 at 11:05am, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and included the following incidents of client to client physical aggression behaviors:</p> <p>-A 9/24/15 BDDS report for an incident on 9/23/15 at 5:45pm indicated client #1 said client #5 "hit him, and kicked his right foot." No injury was noted. No</p>	W 0157	<p><b>To ensure appropriate measures are in place and being utilized and that corrective action is implemented for all trending of client to client physical aggression, the following corrective action(s) will be implemented:</b> 1) The Qualified Intellectual Disabilities Professional will review all BDDS reports that involve client to client aggression for any trending. An Inner Disciplinary Team (IDT) meeting will be called, for any client that has 2 episodes of client to client aggression in a one month time. The IDT meeting will be to determine what corrective measures will be implemented to address the physical aggression, to ensure the health and safety of the client is being taken care of, and that the health and safety of the other clients that reside in the group home are being taken care of as well.</p>	11/18/2015

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	<p>corrective measures were available for review.</p> <p>-A 9/15/15 BDDS report for an incident on 9/15/15 at 2:55pm indicated client #7 "hit" client #5 during transport on the facility van. No corrective measures were available for review.</p> <p>-A 9/1/15 BDDS report for an incident on 8/31/15 at 4:50pm indicated client #7 "told [client #5] to shut up and hit [client #5] in L (left) shoulder, then hit [client #7] in the back of his head." No injuries were noted. No corrective measures were available for review.</p> <p>-An 8/5/15 BDDS report for an incident on 8/5/15 at 5:30pm indicated client #4 "hit" client #6 on the head. No corrective measures were available for review.</p> <p>-An 4/16/15 BDDS report for an incident on 4/13/15 at 3:30pm indicated client #7 "pushed" client #6 on her back while walking. No injury was noted. No corrective measures were available for review.</p> <p>-A 3/11/15 BDDS report for an incident on 3/11/15 at 3:30pm indicated client #7 was asked to bring in the trash container, client #7 "shoved" client #3 in the back and "again on the side of his face with an</p>			

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	<p>open hand." No corrective measures were available for review.</p> <p>-A 3/11/15 BDDS report for an incident on 3/11/15 at 2:50pm indicated client #7 "hit" client #4. No corrective measures were available for review.</p> <p>-A 2/26/15 BDDS report for an incident on 2/8/15 at 9:00am indicated client #3 was in the kitchen, staff asked client #3 if he wanted toast, and client #4 "got up and slapped [client #3] twice in the face." No corrective measures were available for review.</p> <p>-A 2/18/15 BDDS report for an incident on 2/18/15 at 3:30pm indicated client #4 "pushed" client #7, client #7 "swung and with an open hand hit L (left) shoulder, then [client #7] pushed [client #6]." No corrective measures were available for review.</p> <p>-A 2/17/15 BDDS report for an incident on 2/17/15 at 1:20pm indicated "another client wanted [client #3's] chair and kicked him in the face." The report indicated a red mark under client #3's left eye. No corrective measures were available for review.</p> <p>-A 2/4/15 BDDS report for an incident on 2/3/15 at 3:45pm indicated client #4</p>			

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	<p>"pushed" client #7 on the "back after (becoming) anxious," and "pushed" client #6. No corrective measures were available for review.</p> <p>-A 1/25/15 BDDS report for an incident on 1/24/15 at 5pm indicated client #4 hit client #5 in her back. No corrective measures were available for review.</p> <p>-A 1/12/15 BDDS report for an incident on 1/11/15 at 1:00pm indicated client #7 "hit" client #2 on the "top of his head and pushed" client #4. No injuries were noted. No corrective measures were available for review.</p> <p>-A 1/7/15 BDDS report for an incident on 1/7/15 at 12:40pm indicated client #5 was "hit by another (unidentified) client on the shoulder because the other client wanted [client #5's] item." No injury was noted. No corrective measures were available for review.</p> <p>-A 12/23/14 BDDS report for an incident on 12/22/14 at 11:15am indicated client #2 was "pushed by other" unidentified clients. No injury was noted. No corrective measures were available for review.</p> <p>-A 12/1/14 BDDS report for an incident on 11/30/14 at 7:55pm indicated client #4</p>			

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	<p>"pushed" client #2 and hit client #7. No corrective measures were available for review.</p> <p>-A 11/24/14 BDDS report for an incident on 11/23/14 at 8:00pm indicated client #7 had asked for "batteries," began to obsess over batteries, walked to the desk, walked to client #6 "hit her with an open hand to the back, then hit [client #5] on the L (left) side of face." No injuries were noted. No corrective measures were available for review.</p> <p>-A 11/19/14 BDDS report for an incident on 11/18/14 at 3:30pm indicated client #5 "hit" client # on the left shoulder, client #1 "pulled down" client #5, and staff separated the two clients. No injuries were noted. No corrective measures were available for review.</p> <p>-A 11/7/14 BDDS report for an incident on 11/6/14 at 8:00am indicated client #5 "hit" client #6 on her forehead while passing her in the hallway. No injury noted. No corrective measures were available for review.</p> <p>-A 11/3/14 BDDS report for an incident on 11/2/14 at 8:15pm indicated client #5 said client #4 hit her in the face. No corrective measures were available for review.</p>			

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W 0227  Bldg. 00	<p>On 10/16/15 at 2:45pm and on 10/19/15 at 4:00pm, interviews were conducted with the DRS (Director of Residential Services). The DRS indicated no corrective measures were documented and/or available for review after clients #1, #2, #3, #4, #5, #6, and #7 continued to be involved in client to client physical aggression behavior incidents.</p> <p>9-3-2(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on observation, record review, and interview, for 2 of 4 sampled clients (clients #3 and #4), the facility failed to develop a program to address client #3 and #4's identified incontinence needs at night.</p> <p>Findings include:</p> <p>On 10/6/15 from 6:00am until 8:45am, observation and interviews were completed at the group home. At 6:20am, Group Home Staff (GHS) #2 and GHS #5 both indicated clients #3 and #4 were incontinent of urine at night and</p>	W 0227	<p><b>To ensure that allclients, that have nighttime incontinence, have a nighttime toileting programand a nighttime toileting tracking sheet that is utilized, the followingcorrective action(s) will be implemented:</b></p> <p>Qualified Intellectual Disabilities professional(QIDP) will ensure that all clients, that have nighttime incontinence, has a nighttime toileting program in place, and a nighttime toileting tracking sheetthat is being utilized by the staff in the home. QIDP will revise the Toiletingrisk</p>	11/18/2015			

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	<p>both clients' beds were wet with urine. At 6:20am, GHS #5 indicated staff on duty at the group home got clients #3 and #4 up during the night to use the bathroom and stated both clients were "sometimes" still wet in the morning. At 6:40am, client #4 was assisted to the shower because of incontinence. At 7:45am, GHS #2 carried client #4's urine soaked linens to the washer. At 8:00am, GHS #2 and GHS #5 both indicated clients #3 and #4 were incontinent of urine at night and no goals/objectives and/or schedules for night time toileting were available for review. At 8:05am, client #3 was awakened for the day by GHS #7 and assisted to the bathroom. GHS #7 indicated client #3 had been incontinent of urine in his bed. At 8:20am, GHS #7 carried client #3's urine soaked bed linens to the washer and filled the washer.</p> <p>Client #3's record was reviewed on 10/13/15 at 9:49am. Client #3's 4/2015 ISP (Individual Support Plan) indicated a goal to complete toilet and hygiene skills. Client #3's ISP indicated he "initiates using the restroom. He needs supervision in the restroom due to inappropriate handling of bodily waste and pica." Client #3's plans did not indicate a night time toileting goal and/or toileting schedule for the night time period. Client</p>		<p>plans for all consumers that have nighttime incontinence to reflect the toileting guidelines for staff to follow through the night. All staff in the home will be trained 1) on all nighttime incontinence programs, nighttime toileting tracking sheet, and all revised toileting risk plans. (appendixc) All record of training's will be completed following staff training's and will be submitted to the Residential House Manager for administrative oversight.</p>	

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	<p>#3's record did not indicate evidence of training to address client #3's incontinence. Client #3's record indicated he could use the toilet during the day independently.</p> <p>Client #4's record was reviewed on 10/13/15 at 10:35am. Client #4's 5/2015 ISP (Individual Support Plan) indicated a goal/objective to wipe after toileting with two or less verbal prompts. Client #4's ISP indicated client #4 "requires staff support to toilet. It helps [client #4] if he can use or see his cue cards to clean up properly after using the toilet." Client #4's record did not include a toileting goal/objective to address his incontinence of bladder at night. Client #4's ISP indicated he was incontinent "at times" and wore adult briefs. Client #4's record did not indicate evidence of training to address client #4's incontinence.</p> <p>On 10/16/15 at 2:45pm, an interview with the Director of Residential Services (DRS) was conducted. The DRS indicated clients #3 and #4 were incontinent of bladder during the night time hours and the clients did not have a schedule or goal available for review. The DRS indicated no further information was available for review.</p> <p>9-3-4(a)</p>			

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W 0327  Bldg. 00	<p>483.460(a)(3)(iv) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the American Academy of Pediatrics, or both. Based on interview and record review, for 1 of 4 sampled clients (client #3), the facility failed to complete client #3's Mantoux (tuberculin skin test) and/or screening.</p> <p>Findings include:</p> <p>On 10/13/15 at 9:49am, client #3's record was reviewed. Client #3's 3/5/15 and 2/27/14 physician's visits did not include a completed Mantoux skin test.</p> <p>On 10/16/15 at 2:45pm, an interview with the Director of Residential Services (DRS) was conducted. The DRS indicated clients living in the group home should receive a yearly Mantoux/Tuberculin skin test and/or a tuberculosis screening. The DRS indicated no further information was available for review.</p> <p>On 10/19/15 at 4:00pm, an interview</p>	W 0327	<p><b>To ensure that appropriate measures are in place and being followed to ensure that all clients receive their annual Mantoux (tuberculin skin test) and/or screening and our compliant with that testing, the following corrective action(s) will be implemented:</b></p> <p>1) The Residential Nurse will ensure that all clients receive their Mantoux (tuberculin skin test) and/or screening annually. To ensure that all clients receive their annual Mantoux all consumers that reside in the Residential Department will receive their annual Mantoux test and/or screening during the same month every year. This will be done for all the clients in the same month to ensure compliance with their testing.</p> <p>2) Residential Nurse will administer client #3's Mantoux (tuberculin skin test) and/or screening to ensure this client</p>	11/18/2015

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W 0383 Bldg. 00	<p>with the agency LPN (Licensed Practical Nurse) and the DRS was conducted. Both professional staff indicated no further information was available for review.</p> <p>9-3-6(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area. Based on observation, record review, and interview, the facility failed to secure the medication cabinet keys for 4 of 4 sampled clients (#1, #2, #3, and #4) and 4 additional clients (clients #5, #6, #7, and #8) who resided in the home.</p> <p>Findings include:</p> <p>On 10/5/15 from 4:00pm until 5:45pm and on 10/6/15 from 6:00am until 8:45am, observation and interview were completed at the group home with clients #1, #2, #3, #4, #5, #6, #7, and #8. On 10/5/15 from 4:45pm until 5:45pm, the medication closet keys lay unsecured on top of the living room television cabinet at eye level. At 5:45pm, the RM (Residential Manager) indicated the keys which had laid unsecured on top of the living room television cabinet were the medication closet keys and indicated the</p>	W 0383	<p>iscompliant with their testing.</p> <p><b>Toensure that the medication cart keys are always secure, the followingcorrective action(s) will be implemented:</b></p> <p>1) ResidentialNurse will do a training on securing the medication keys and each shift havinga designated key holder. ResidentialNurse will put emphasis on securing the medication key and having a key holderon each shift. (Appendix D) All record of training's will be completedfollowing staff training's and will be submitted to the Residential HouseManager for administrative oversight.</p>	11/18/2015	

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	<p>keys were not secured when left laying there.</p> <p>On 10/6/15 at 7:18am, GHS (Group Home Staff) #7 verbally asked clients #1, #2, #4, and #6 to load into the facility van for the first van transport to day services. At 7:55am, clients #1, #2, #4, and #6 left with GHS #11 on the facility van for day services and GHS #11 carried a black locked box. At 8:05am, the exit/entrance door chimed and GHS #11 returned to the group home from the first van transport to day services. GHS #11 entered the group home, walked to the living room, laid a locked black medication box on top of the television cabinet in the living room, and then placed the medication keys to the box on top of the locked medication box. GHS #11 then walked away from the unsecured medication keys. At 8:20am, clients #3, #6, #7, and #8 walked and accessed the living room area unsupervised by the facility staff. At 8:40am, the RM indicated the medication box left unsecured sitting on the television cabinet inside the living room with the medication keys on top of the box was not secured. The RM indicated the keys were for the medication box which was left unattended in the living room. The RM opened the medication box, indicated the box was used for staff</p>				

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W 0436 Bldg. 00	<p>to transport clients with their emergency injectable seizure medications. The RM indicated the keys to the box should have been secured.</p> <p>An interview was conducted on 10/8/15 at 10:35am, with the agency LPN (Licensed Practical Nurse). The LPN indicated the medication keys should be kept secured when medications were not administered and the keys were not secured. The LPN indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 had access to the medication keys to the medication closet and transport medication box. The LPN indicated the facility followed "Living in the Community" Core A/Core B procedures for medication administration.</p> <p>On 10/8/15 at 11:00am, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated in "Core Lesson 3: Principles of Administering Medication" medication cabinet keys and keys for medications should be kept secure.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good</p>			

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	<p>repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview, for 3 of 4 sampled clients (clients #2, #3, and #4) with adaptive equipment, the facility failed to have client #2's hearing aid available and in good repair, failed to have available and encourage clients #3 and #4 to use their communication system to communicate their wants/needs, and failed to have available and encourage client #4 to have unimpeded access and to wear his prescribed eye glasses when opportunities existed.</p> <p>Findings include:</p> <p>1. On 10/5/15 from 4:00pm until 5:45pm and on 10/6/15 from 6:00am until 8:45am, observation and interview were completed at the group home. Client #2 wore his left hearing aid and did not wear a hearing aid in his right ear. On 10/6/15 at 7:45am, client #2 indicated his left hearing aid was broken and stated the left aid had been broken "over three (3) months." At 7:55am, the RM (Residential Manager) stated client #2's left hearing aid had been broken "over three (3) months."</p>	W 0436	<p><b>Toensure proper execution and implementation of the vision, communication, andhearing risk plans and programs for Client #2, #3, and #4, the followingcorrective action(s) will be implemented:</b></p> <p>1) The Residential House Manager will retrainall staff that work in the group home on all vision, communication, and hearingrisk plans and programs for Clients #2, #3, and #4. (Appendix E) Allrecord of trainings will be completed following staff trainings and will besubmitted to the Residential House Manager for administrative oversight.</p> <p>2) The Residential Nurse will ensure that allclients hearing aids and prescription glasses are in proper working conditionand accessible for staff.</p> <p>1) Qualified Intellectual Disability Professional(QIDP) will ensure all vision, hearing, and communication risk plans andprograms are updated to meet the current needs of clients #2, #3, and #4. QIDPwill ensure that all communication picture</p>	11/18/2015			

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	<p>On 10/13/15 at 12:35pm, client #2's record was reviewed. Client #2's 4/10/15 ISP (Individual Support Plan) indicated he wore right and left hearing aids. Client #2's 2/19/15 hearing assessment and 2/19/15 History and Physical both indicated he wore right and left prescribed hearing aids.</p> <p>On 10/16/15 at 2:45pm, an interview with the Director of Residential Services (DRS) was conducted. The DRS indicated client #2 wore hearing aids in his right and left ears. The DRS indicated she would need to follow up with staff to determine the status of client #2's left hearing aid repair. The DRS indicated no further information was available for review.</p> <p>On 10/19/15 at 4:00pm, an interview with the DRS and QIDP (Qualified Intellectual Disabilities Professional) was conducted. Both staff indicated no further information was available for review.</p> <p>2. On 10/5/15 from 4:00pm until 5:45pm and on 10/6/15 from 6:00am until 8:45am, observation and interview were completed at the group home with client #3. During both observation periods client #3 was non verbal and reacted to</p>		<p>cue cards are available for staff touse with client #3. QIDP will retrain staff on communication picture cue cards that are to be used with client #3. (appendix E) All record of training's will be completed following staff training's and will be submitted to the ResidentialHouse Manager for administrative oversight.</p>				

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	<p>staff's verbal requests. Client #3 did not initiate communication with the staff. No communication system was observed available, taught, and encouraged for client #3 to communicate with staff.</p> <p>Client #3's record was reviewed on 10/13/15 at 9:49am. Client #3's 4/2015 ISP (Individual Support Plan) indicated a goal to use picture cards to communicate needs and wants to others. Client #3's 11/6/2013 "Individual Specific Information" indicated client #3 was "non verbal and relies on staff for communication. He uses pictures cue cards to tell staff when he wants to use the restroom."</p> <p>On 10/16/15 at 2:45pm, an interview with the Director of Residential Services (DRS) was conducted. The DRS indicated client #3 was non verbal and used communication pictures to communicate. The DRS indicated no further information was available for review.</p> <p>3. On 10/5/15 from 4:00pm until 5:45pm, observation and interview were conducted and client #4 wore prescribed eye glasses. During the observation period client #4 was non verbal and used a few sign language signs to attempt to convey his wants/needs to staff. At</p>			

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	<p>4:25pm, GHS (Group Home Staff) #7 stated she knew "limited" signs and signed to client #4 to ask him to take his medication. Client #4 smiled, shook his head yes, and took his medication. GHS #7 indicated not all staff at the group home knew sign language to communicate with client #4. During the observation period client #4 pulled on staff's hands and arms to take the staff person to what he wanted. No communication system was observed available, taught, and encouraged for client #4 to communicate with staff who did not know sign language.</p> <p>On 10/6/15 from 6:00am until 7:55am, observation and interview were completed at the group home with client #4. From 6:00am until 7:22am, client #4 did not wear prescribed eye glasses. From 6:00am until 7:55am, client #4 was not prompted and/or encouraged to use sign language and/or a communication system to communicate his wants/needs. At 7:18am, client #4 came to the medication closet with GHS #8. GHS #8 indicated client #4 was non verbal and GHS #8 did not know sign language. At 7:22am, GHS #8 took out client #4's eye glasses from a locked cabinet and gave him his prescribed eye glasses to wear. Client #4 was not prompted and encouraged to use a communication</p>			

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	<p>system to communicate his wants and needs.</p> <p>Client #4's record was reviewed on 10/13/15 at 10:35am. Client #4's 12/4/14 "Visual Services" assessment indicated client #4 wore prescribed eye glasses to see. Client #4's 4/15/11 "Speech Evaluation" indicated a recommendation, "could benefit from increased use of pictures, gestures for communication of wants/needs." Client #4's 5/2015 ISP (Individual Support Plan) indicated a goal/objective to increase his communication, to learn sign language with 50% accuracy, to clean his glasses with one verbal prompt, and to use cue cards rather than pulling on staff for communication. Client #4's ISP indicated he wore his prescribed eye glasses when he got up in the mornings and did not indicate client #4's eye glasses were kept locked in the medication closet. Client #4's toileting goal indicated client #4 "requires staff support to toilet. It helps [client #4] if he can use or see his cue cards to clean up properly after using the toilet...Staff should show [client #4] his cue card" to wash his hands and to communicate with client #4.</p> <p>On 10/16/15 at 2:45pm, an interview with the Director of Residential Services</p>			

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W 0440 Bldg. 00	<p>(DRS) was conducted. The DRS indicated client #4 was non verbal and staff were to use cue cards and/or sign language to communicate with client #4. The DRS indicated she was not aware client #4's eye glasses were kept locked inside the medication closet. The DRS indicated no further information was available for review.</p> <p>9-3-7(a)</p> <p>483.470(i)(1) EVACUATION DRILLS</p> <p>The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed for 4 of 4 sampled clients (#1, #2, #3, and #4) and 4 additional clients (#5, #6, #7, and #8), to ensure a completed evacuation drill was conducted at least every 90 days for the day shift (7:00 AM - 3:00 PM), evening shift (12:00noon - 8:00 PM and 1:00 PM - 9:00 PM), and night shift (9:00 PM - 7:00 AM) of personnel.</p> <p>Findings include:</p> <p>The facility's evacuation drills were reviewed on 10/6/15 at 7:45am. The review indicated the facility had failed to conduct a complete evacuation drill for clients #1, #2, #3, #4, #5, #6, #7, and #8</p>	W 0440	<p><b>To ensure that allevacuation drills are done for each client that resides in the group home atleast quarterly for each shift of personnel, thefollowing corrective action(s) will be implemented:</b></p> <p>1) The Residential House Manager and TheResidential team Lead will ensure that all evacuation drills are complete foreach client that resides in the group home; and at least once quarterly foreach shift of personnel. The Residential House Manager and the Residential teamLead will look over all completed evacuation drills monthly to ensure thatstaff has documented the duration of the drill on every completed form.</p>	11/18/2015			

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	<p>for the period before 1/20/2015 and after 9/22/2014 calendar year for the day, evening, and night shifts of personnel. The review indicated the following incomplete evacuation drills for the period before 1/20/15:</p> <ul style="list-style-type: none"> <li>-12/20/14 at 2am, no duration</li> <li>-12/18/14 at 1am, no duration</li> <li>-12/15/14 at 3am, no duration</li> <li>-12/9/14 at 10:00pm, no duration</li> <li>-11/22/14 at 5:00pm, no duration</li> <li>-11/18/14 at 9:00pm, no duration</li> <li>-11/12/14 at 3:30pm, no duration</li> <li>-10/25/14 at 4:30am, no duration</li> <li>-10/22/14 at 9:00am, no duration</li> <li>-10/19/14 at 7:45am, no duration.</li> </ul> <p>An interview with the Director of Residential Services (DRS) was conducted on 10/6/15 at 11:05am. The DRS indicated the day shift of personnel was 7:00am until 3:00pm daily, the evening shift of personnel was 12noon until 8:00pm and 1:00pm until 9:00pm, and the night shift of personnel was 9:00pm until 7:00am. The DRS indicated the evacuation drills before 1/20/15 did not include a length of time for the completion of each drill and the drill was incomplete. The DRS indicated she was unable to locate any further evacuation drills for clients #1, #2, #3, #4, #5, #6, #7, and #8.</p>		<p>1) The Residential House Manager will do a retraining for all staff that work in the group home on the appropriate way to run all evacuation drills and how to appropriately complete the paperwork. (Appendix F) All record of training's will be completed following staff training's and will be submitted to the Residential House Manager for administrative oversight.</p>	

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W 0455 Bldg. 00	<p>An interview with the DRS was conducted on 10/16/15 at 2:45pm. The DRS indicated she was unable to locate any further evacuation drills for clients #1, #2, #3, #4, #5, #6, #7, and #8.</p> <p>9-3-7(a)</p> <p>483.470(l)(1) INFECTION CONTROL</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation, record review, and interview, for 3 of 4 sampled clients (clients #1, #2, and #4) and 3 additional clients (clients #5, #6, and #8), the facility failed to implement and teach sanitary methods when opportunities existed.</p> <p>Findings include:</p> <p>1. On 10/5/15 from 4:12pm until 4:40pm, GHS (Group Home Staff) #7 completed medication administration with clients #4, #5, #6, and #8. At 4:12pm, GHS #7 selected client #8's oral medications for administration. Client #8 rubbed the scabs on his right forearm and the back of his neck. Client #8 was not taught/encouraged to wash his hands and was prompted to take his medications. Client #8 took his oral medications with</p>	W 0455	<p>To ensure all clients that reside in the grouphome have active programming for the prevention, control, and investigation of infection and communicable disease, the following corrective action(s) will be implemented:</p> <p>1) Qualified Intellectual Disabilities Professional(QIDP) will ensure that all clients that reside in the home have daily informalhand washing program goals for before meals and before medication administrationpasses.</p> <p>1) ResidentialHouse Manager/Residential Nurse will do a retraining for all staff in the homeHand washing. (Appendix G) All record of training's will be completed followingstaff training's and will be submitted to the Residential House Manager foradministrative oversight.</p>	11/18/2015

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	<p>water and left the medication room. No handwashing was observed. At 4:25pm, GHS #7 selected client #4's oral medications for administration. Client #4 used sign language with staff to identify his medication and himself, client #4 smiled, and took his oral medication with water. No handwashing was observed. At 4:30pm, GHS #7 selected client #5's oral medications for administration. Client #5 was not taught/encouraged to wash her hands and was prompted to take her medications. Client #5 took her oral medications with water and left the medication room. No handwashing was observed. At 4:35pm, GHS #7 selected client #6's oral medications for administration. Client #6 took her oral medication with water, unscrewed the top off the prescribed eye medication, client #6 and GHS #7 placed one drop of the medication into her left eye, and replaced the cap on the bottle. No handwashing was observed.</p> <p>2. On 10/6/15 from 6:00am until 8:45am, observation and interviews were conducted at the group home. At 6:50am, client #1 blew his nose and did not wash his hands. At 6:50am, client #5 scratched her bottom under her bedpants and did not wash her hands. From 6:50am until 7:18am, clients #1, #2, #4, #5, and #6 independently walked to the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G732	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/19/2015
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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1730 OSAGE DR KOKOMO, IN 46902
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	<p>freezer. Each client retrieved two frozen waffles from the same package left inside the freezer with their hands, and did not wash their hands. From 6:50am until 7:18am, clients #1, #2, #4, #5, and #6 were prompted by GHS #1, GHS #7, and GHS #11 to each assemble and place their table setting on the table and no handwashing was observed. At 7:00am, client #2 loaded his dirty laundry into the washer and returned to the kitchen to retrieve two waffles from the freezer without washing his hands. At 7:00am, client #4 peeled a banana, handled the raw fruit with his fingers, cut the banana on a plate, and did not wash his hands. At 7:10am, client #1 located a breakfast sandwich from the freezer, unwrapped the sandwich, placed it on a paper towel inside the microwave, and no handwashing was observed. At 7:18am, clients #1, #2, #4, #5, and #6 were finishing eating their breakfast, carried their dishes to the sink, and no handwashing was observed.</p> <p>On 10/8/15 at 10:35am, an interview with the agency nurse was conducted. The agency nurse indicated staff should ensure clients #1, #2, #4, #5, and #6 washed their hands before medication administration and before breakfast/cooking food was completed. The agency nurse indicated the facility</p>			

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	<p>followed Universal Precautions to prevent the spread of infection. The agency nurse indicated the facility followed the Core A/Core B training for Universal Precautions.</p> <p>On 10/16/15 at 2:45pm, an interview was conducted with the DRS (Director of Residential Services). The DRS indicated the facility followed Core A/Core B Medication Administration Training for Universal Precautions. The DRS indicated clients #1, #2, #4, #5, and #6 should be taught to wash their hands before medication administration and before dining/cooking.</p> <p>On 10/8/15 at 11:00am, the undated Core A/Core B Medication Administration training manual page 3 indicated "Universal precautions" included washing hands before medication administration, before eating, and after using the restroom.</p> <p>9-3-7(a)</p>			