

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G802	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/27/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: 5/24, 5/25, 5/26 and 5/27/16.</p> <p>Facility number: 012527 Provider number: 15G802 AIM number: 201024860</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 6/6/16.</p>	W 0000		
W 0125 Bldg. 00	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, interview and record review for 1 of 4 sampled clients (#3), the facility failed to ensure the</p>	W 0125	<p>Finding(s)</p> <p>1. "Based on observation, interview and record review for</p>	06/24/2016

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G802		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/27/2016	
NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>rights of client #3 in regard to the use of door alarm for monitoring a client with inappropriate sexual behavior. The facility failed to ensure the client had a plan in place which indicated what the client had to do to get his right of freedom of movement back.</p> <p>Findings include:</p> <p>During the 5/24/16 observation period between 4:00pm and 5:45pm and the 5/25/16 observation period between 7:00am and 8:30am client #3 had an active door alarm on his bedroom door.</p> <p>Client #3's record was reviewed on 5/26/16 at 1:35pm. Client #3's September 2015 BSP (Behavior Support Plan) indicated client #3 had a targeted behavior of sexual aggression/sexual predator/grooming. Client #3's BSP indicated "Sexual aggression includes any type of sexual contact with another person that is unwanted. [Client #3] has a history of targeting low functioning individuals. Sexual aggression toward individuals such as touching or grabbing private parts is also physical aggression. [Client #3] has a history of being a sexual predator and needs staff supervision at all times. [Client #3] will give others items to groom them for sexual favors. [Client #3] will go into other's bedrooms wanting</p>		<p>1 of 4 sampled clients (#3), the facility failed to ensure the rights of client #3 in regard to the use of door alarm for monitoring a client that had sexual inappropriate behavior. The facility failed to ensure that the client had a plan in place which indicated what the client had to do to get his right of freedom of movement back. "</p> <p>Corrective Action(s):</p> <p>To ensure that established plans are written and in place for the clients to get their right of freedom of movement back, the following corrective actions will be implemented:</p> <p>1. The Qualified Intellectual Disabilities Professional (QIDP) will write and implement titration plans for client #3 to get their right of freedom of movement back. The QIDP will obtain approval for these plans from the Human Rights Committee (HRC) prior to implementation. All staff located in the home will be trained on client #3's titration plans. All record of trainings will be completed following staff trainings and will be submitted to the Residential Director for administrative oversight.</p> <p>-</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G802	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/27/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0154	<p>sexual contact. [Client #3] had HRC (Human Rights Committee) and guardian approved door alarms on his bedroom door, he has a bedroom by himself, and has a bed alarm. Direct support professionals will ensure that all alarms in [client #3's] room are always on before he goes to bed, do every 15 minute bed checks/alarm checks during sleep hours, and notify QIDP (Qualified Intellectual Disabilities Professional) or RHM (Residential House Manager) immediately if alarms are not working properly. Direct support professionals will document all bed checks on the midnight bed check and notify on call immediately for any issues or concerns". Client #3's BSP did not indicate what client #3 had to do to have the door alarms removed from his bedroom door.</p> <p>An interview with the RD (Residential Director) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 5/26/16 at 2:26pm. When asked if client #3 had a titration plan for the use of the door alarms on his bedroom door, the RD stated "No".</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G802	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/27/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 00	<p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 2 of 9 investigations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to complete a thorough investigation of an injury of unknown source for client #4 and possible abuse for client #4.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and investigations were reviewed on 5/24/16 at 11:35am. The investigations indicated the following (not all inclusive):</p> <p>-The 5/5/16 reportable incident report indicated "While at Day programming, [Client #4] was laying on a bean bag with his arms over his head, when staff noticed three circular bruises in a line measuring from 1/4" (inch) to 1/2" located on his left forearm. [Client #4] mentioned that he received the bruise from home but was unclear to what had occurred".</p> <p>The 5/11/16 completed investigation in regards to the 5/5/16 reportable incident indicated client #4, Staff #1, #2, #3, #4, #5, #6, #7 and the Team Lead were all</p>	W 0154	<p>W154</p> <p>Finding(s):</p> <p>1. "Based on record review and interview for 2 of 9 investigations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to complete a thorough investigation of an injury of unknown source for client #4 and possible abuse for client #4."</p> <p>Corrective Action(s):</p> <p>To ensure that established agency policies and procedures for investigations are being implemented, corrective measures/actions are being implemented and executed as written in regard to retraining staff for all clients. To ensure that established agency policies and procedures for conducting thorough investigations are being implemented for all allegations of abuse, neglect and/or injuries of unknown source.</p> <p>1. All investigations will be conducted in the manner outlined on the Residential Services Investigation Process. All investigations include appropriate corrective action and that all corrective actions/measures are implemented in regards to retraining staff for clients. To</p>	06/24/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G802	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/27/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>interviewed during the investigation. The investigation did not indicate any day programming staff were interviewed during the investigation.</p> <p>An interview with the RD (Residential Director), the Social Services Coordinator and the Assistant Director was conducted on 5/25/16 at 10:28am. When asked if any staff from the day programming was interviewed during the investigation, the Social Services Coordinator stated "They were but we do not have written statements for Day Program staff".</p> <p>- The 3/17/16 reportable incident report indicated "On 3/16/16 at approximately 8:30pm, [client #4] made an allegation that one of his housemates came into his bedroom, pulled down [client #4's] pants and touched his genitals. The housemate told the Residential QIDP (Qualified Intellectual Disabilities Professional) that he did not go into [client #4's] bedroom. The direct support professional immediately notified on-call of the incident. Direct Support Professionals were instructed to keep the housemate within line of sight of staff at the group home pending a formal investigation".</p> <p>The 3/18/16 interview with client #7 indicated client #7 shared a bedroom with</p>		<p>ensure that all correctiveactions/measures are implemented, a Record of Training form will be completedfor all trainings on corrective actions/measures for the corrective and besubmitted to the Social Service Coordinator for review. The Social ServiceCoordinator will take a copy of the Record of training completed for thetraining and attached it to the investigation to ensure completion. Theinvestigations will be reviewed weekly by the Residential Director to ensuretrainings have been completed in accordance to the implemented correctiveactions/measures.</p> <p>2. Toensure that all investigations are conducted in a uniform and consistentmanner, all Residential House Managers, Qualified Individual DisabilitiesProfessionals, Nurses, Residential Director of Quality Assurance and SocialService Coordinator, and the Social Service Coordinator will be trained on thenewly established investigation process. Record of Training forms will becompleted following staff trainings and will be submitted to the ResidentialDirector for administrative oversight.</p> <p>3. Allstaff located in the home will be retrained on reportable incidents, theprocedure for reporting, and the abuse, neglect, and exploitation policy.Record of</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G802	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/27/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0156 Bldg. 00	<p>client #4. The interview indicated client #7 yelled for help and staff #6 came into the bedroom. The investigation did not indicate staff #6 was interviewed in regards to client #7 yelling for help and him going into the room to assist client #4.</p> <p>An interview with the RD (Residential Director), the Social Services Coordinator and the Assistant Director was conducted on 5/25/16 at 10:28am. When asked if staff #6 was questioned about client #7 yelling for help and him going into the room to assist, the AD stated "No".</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS</p> <p>The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>Based on interview and record review for 2 of 9 investigations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to complete investigations within 5 working days for clients #2, #4, #6 and #8.</p> <p>Findings include:</p>	W 0156	<p>Training forms will be completed following staff trainings and will be submitted to the Residential Director for administrative oversight.</p> <p>W156 Finding(s): 1. "Based on record review and interview for 2 of 9 investigations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to complete the investigations within 5 working business days for clients #2, #4, #6, and #8."</p>	06/24/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G802	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/27/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>The facility's reportable incident reports and investigations were reviewed on 5/24/16 at 11:35am. The investigations indicated the following (not all inclusive):</p> <p>-The 5/22/15 reportable incident indicated "[Client #4] was non-compliant and yelling as staff redirected him at the group home on 5/22/15. At 8:15a [Client #6] became agitated with [client #4] and walked into the room. The staff attempted to block [client #4] from [client #6], but [client #6] reached around her and gently smacked [client #4's] left cheek staying, 'stop it'".</p> <p>The residential investigation checklist in regards to the 5/22/15 client to client abuse between client #4 and client #6 indicated the investigation was opened on 5/26/15 and was closed on 6/18/15.</p> <p>-The 11/10/15 reportable incident indicated "[Client #2] became annoyed with his housemate, [Client #8], as they were going out the door of the group home on 11/10/15 at 8:15am. [Client #2's] behavior quickly escalated. He punched [client #8] in the face twice and pushed him out the door, causing [client #8] to fall to the ground. The team lead immediately separated them and evaluated [client #8]. [Client #8] had a 2</p>		<p>CorrectiveAction(s): Toensure that all investigations for abuse, neglect and/or injuries of unknownsource be completed within 5 working business days:</p> <p>1.TheSocial Service Coordinator and day service programming will be retained oncompletion of all abuse, neglect and/or injuries of unknown sourceinvestigations within 5 working business days. Record of Trainingforms will be completed following staff trainings and will be submitted to theResidential Director for administrative oversight.</p> <p>2.TheResidential Director, Assistant Director and Social Service Coordinator willmeet once a week to go over open investigations and completion due dates. TheAssistant Director has started an Excel spread sheet to track open investigationsto monitor and ensure completion occurs in 5 days for additional administrativeoversight.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G802		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/27/2016	
NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W 0336 Bldg. 00	<p>inch by 1 inch light pink mark on his left cheek, a 1 inch by 1 inch surface abrasion on his right forearm, a 1/2 inch surface abrasion on his left knee, and a 2 inch by 1 inch red surface abrasion on his right knee. First aid was completed on the areas".</p> <p>The residential investigation checklist in regards to the 11/10/15 client to client abuse between client #2 and client #8 indicated the investigation was opened on 11/11/15 and was closed on 11/19/15.</p> <p>An interview with the RD (Residential Director), the Social Services Coordinator and the Assistant Director was conducted on 5/25/16 at 10:28am. When asked how long the facility had to complete their investigations, the RD stated "five working days".</p> <p>9-3-2(a)</p> <p>483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. Based on record review and interview for 4 of 4 sample clients (#1, #2, #3, and #4), the facility failed to provide evidence of a quarterly nursing/health assessment for</p>	W 0336	<p>W336 Finding(s): 1. "Based on record review and interview for 4 of 4 sample</p>	06/24/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G802		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/27/2016	
NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>each of the clients.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 5/25/16 at 12:45pm. Client #1's record included a nursing quarterly assessment completed on 2/11/16. Client #1's record indicated no nursing assessments available for review the months of May 2015, August 2015 and Nov 2015.</p> <p>Client #2's record was reviewed on 5/26/16 at 12:26pm. Client #2's record included a nursing quarterly assessment completed on 2/11/16. Client #2's record indicated no nursing assessments available for review the months of May 2015, August 2015 and Nov 2015.</p> <p>Client #3's record was reviewed on 5/26/16 at 1:35pm. Client #3's record included a nursing quarterly assessment completed on 2/11/16. Client #3's record indicated no nursing assessments available for review the months of May 2015, August 2015 and Nov 2015.</p> <p>Client #4's record was reviewed on 5/25/16 at 1:45pm. Client #4's record included a nursing quarterly assessment completed on 2/11/16. Client #4's record indicated no nursing assessments available for review the months of May</p>				<p>clients (#1, #2, #3, and #4), the facility failed to provide evidence of a quarterly nursing assessment foreach client."</p> <p>CorrectiveAction(s): TheResidential Nurse will complete and document a quarterly nursing/healthassessment for each client that resides in the group home.</p> <p>1.TheResidential Nurse will complete and document a quarterly nursing/healthassessment for every client in the group home.</p> <p>2.A new Residential nurse has been hired andis thoroughly being trained on all policy/procedures including quarterlynursing/health assessments. All record of trainings will be completedfollowing each training and will be submitted to the Residential Director foradministrative oversight.</p> <p>3.The Assistant Director will do a quarterlyPeriodic Service Review and ensure that the nursing/health assessments havebeen completed by The Residential Nurse for administrative oversight.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G802		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/27/2016	
NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W 0362 Bldg. 00	<p>2015, August 2015 and Nov 2015.</p> <p>An interview with the RD (Residential Director) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 5/26/16 at 2:26pm. When asked if the facility had completed nursing assessments for the months of May 2015, August 2015 and November 2015, the RD stated "No."</p> <p>9-3-6(a)</p> <p>483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. Based on interview and record review for 4 of 4 sampled clients (#1, #2, #3, #4), the facility failed to obtain quarterly pharmacy reviews of clients' medications.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 5/25/16 at 12:45pm. Client #1's 2/1/16 physician orders indicated client #1 took routine medication for his health and behavior.</p> <p>Client #1's record indicated the facility only obtained 1 pharmacy review on 2/9/16 within the last year.</p>	W 0362	<p>W362 Finding(s): 1. "Based on record review and interview for 4 of 4 sampled clients (#1, #2, #3, #4), the facility failed to obtain quarterly pharmacy reviews for his health and behavior."</p> <p>Corrective Action(s): The facility will obtain quarterly pharmacy reviews of all clients' medications. 1. The Residential Director will obtain quarterly pharmacy reviews for all clients' medications and ensure that copies are kept in the</p>	06/24/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G802	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/27/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Client #2's record was reviewed on 5/26/16 at 12:26pm. Client #2's 2/4/16 physician orders indicated client #2 took routine medication for his health and behavior.</p> <p>Client #2's record indicated the facility only obtained 1 pharmacy review on 2/9/16 within the last year.</p> <p>Client #3's record was reviewed on 5/26/16 at 1:35pm. Client #3's 2/1/16 physician orders indicated client #3 took routine medication for his health and behavior.</p> <p>Client #3's record indicated the facility only obtained 1 pharmacy review on 2/9/16 within the last year.</p> <p>Client #4's record was reviewed on 5/25/16 at 1:45pm. Client #4's 2/1/16 physician orders indicated client #4 took routine medication for her health and behavior.</p> <p>Client #4's record indicated the facility only obtained 1 pharmacy review on 2/9/16 within the last year.</p> <p>An interview with the RD (Residential Director) and the QIDP (Qualified Intellectual Disabilities Professional) was</p>		main office.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G802	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/27/2016
NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 0460 Bldg. 00	<p>conducted on 5/26/16 at 2:26pm. When asked if the facility had obtained pharmacy reviews prior to 2/9/16, the RD stated "We did, but we can't find the papers."</p> <p>9-3-6(a)</p> <p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>Based on observation, record review, and interview for 4 of 4 sampled clients (#1, #2, #3, and #4) and 4 additional clients (#5, #6, #7, and #8) the facility failed to serve all items on the menu.</p> <p>Findings include:</p> <p>During the 5/24/16 observation period between 4:00pm and 5:45pm, the undated menu posted on the group home's refrigerator indicated the following: Shrimp Stir Fry, Stir Fry vegetables, Instant brown Rice, Watermelon or Cantaloupe, Chilled milk and coffee or tea. At 5:06pm clients #1, #2, #3, #4, #5, #6, #7, and #8 fixed their plates for dinner. They were served an unmeasured amount of ham and beans, a piece of corn bread and a scoop of rice.</p>	W 0460	<p>W460 Finding(s): 1. "Based on record review, observation and interview for 4 of 4 sampled clients (#1, #2, #3, #4), and 4 additional clients (#5, #6, #7, and #8) the facility failed to serve all items on the menu.."</p> <p>Corrective Action(s): The facility will serve all items on the menu at meal times. 1. All staff located in the group home will be retrained on family style dining. All record of trainings will be completed following each training and will be submitted to the Residential Director for administrative oversight. 2. The Residential House Manager and Residential Lead will observe one meal a week to ensure that family style dining is being provided and that the menu</p>	06/24/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G802	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/27/2016
NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Clients #1, #2, #3, #4, #5, #6, #7, and #8 were not offered fruit to eat during their meal.</p> <p>An interview with the RD (Residential Director) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 5/26/16 at 2:26pm. When asked if clients should serve all items on the menu the RD stated "Yes".</p> <p>9-3-8(a)</p>		is being followed for additional monitoring.		