

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  10/31/2013
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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901
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W000000	<p>This visit was for the investigation of Complaint #IN00137327.</p> <p>Complaint #IN00137327: SUBSTANTIATED, Federal and state deficiencies related to the allegations are cited at W102, W104, W122, W149, W154, W157, W189, W322 and W331.</p> <p>Dates of survey: October 7, 8, 11 and 31, 2013</p> <p>Facility number: 012527 Provider number: 15G802 AIM number: 201024860</p> <p>Surveyor: Christine Colon, QIDP</p> <p>The following deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed November 12, 2013 by Dotty Walton, QIDP.</p>	W000000		

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

TITLE

(X6) DATE

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

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W000102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Governing Body for 2 of 4 sampled clients(A and B) and 2 additional clients (D and H). The governing body failed to ensure the facility implemented its policy and procedures to protect the clients rights by preventing sexual abuse and conducting thorough investigations. The governing body neglected to ensure the facility put corrective measures in place to prevent sexual abuse. The governing body neglected to ensure the facility's nursing services met the health care needs of clients A and B by failing to conduct assessments after sexual abuse, and to ensure nursing services trained facility staff to meet the health care needs and provided supervision to prevent sexual abuse. The governing body neglected to ensure client A followed up with his physician as recommended by the emergency room/ER physician.</p> <p>Findings include:</p> <p>1. Please refer to W122. The governing body failed to ensure the facility met the Condition of Participation: Client</p>	W000102	<p>1. All direct care staff, residential nurse,residential house manager and QDDP will be retrained on DDRS guidelines relatedto Abuse, Neglect and Exploitation on November 26, 2013. This training is done annually for all staffas part of BDDS policy training. Asecond training will be added to the training schedule (Appendix A) to ensurethat all staff are trained twice annually. This extra training is important to emphasize the seriousness of thetopic and to serve as a reminder of the policy for dealing with allegations.HRC approval was obtained to leaveall bedroom doors open at night when consumers are sleeping to aid insupervision and ensure an extra measure of safety. All consumers agree to this measure.15 minute bed checks have beenimplemented, the documentation form for nightly checks has been revised andwill be documented by midnight shift (Appendix B). All direct care staff, residential nurse,residential house manager and QDDP will be trained on this process on November26, 20132. The agency policy related to conducting thoroughinvestigations was updated in October 2013 and</p>	11/26/2013			

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	<p>Protections for 2 of 4 sampled clients (A and B) and 2 additional clients (D and H). The governing body failed to implement its written policies and procedures to prevent abuse of clients. The facility failed to put in place sufficient/effective corrective measures to prevent sexual abuse.</p> <p>2. Please refer to W104. The governing body failed for 2 of 4 sampled clients and 2 additional clients (clients A, B, D and H), to exercise general operating direction in a manner 1. to ensure the facility developed and implemented policy and procedures in regards to conducting thorough investigations and documentation of incident reports 2. to provide oversight to ensure their "Prohibition of Violations of Individual Rights" policy was implemented.</p> <p>3. Please refer to W149. The facility neglected for 2 of 4 sampled clients ) A and B) and 2 additional clients (D and H), to implement written policy and procedures to prevent alleged sexual abuse. The facility neglected to conduct thorough investigations in regards to alleged sexual abuse. The facility neglected to put in place effective measures to prevent alleged sexual abuse. The facility neglected to ensure nursing services assessed clients after alleged</p>		<p>approved by the Bona Vista Boardof Directors (Appendix C). All directcare staff, residential nurse, residential house manager and QDDP will be trainedon the agency policy relating to conducting investigations. Investigation policy will be trained onannually (Appendix A). All direct care staff, residential nurse, residential house manager and QDDP willbe retrained on Incident reporting (Appendix D) and all associateddocumentation on November 26, 2013. Emphasis will be placed on immediately documenting any allegations ofANE, and reporting the incident immediately to management. To ensure the "Prohibition of Violations ofIndividual Rights" policy (Organizational Section 04) (Appendix E) is understood and implemented, all staff will be trained on November 26, 2013 andwill be retrained each November and May. This will be added to annual trainingschedule (Appendix A). 3. The survey indicates that the "facility failedto implement written policy and procedures to prevent alleged sexual abuse",however, the allegation of sexual abuse was unsubstantiated indicating that theprocedures in place were implemented. It was determined by the investigation atBona Vista and was corroborated by Adult Protective Services as well as the ERphysician, that this appeared</p>				

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	<p>incidents of sexual abuse, neglected to ensure client A followed up with his physician as recommended by the ER physician and to ensure staff were adequately trained to provide supervision of clients to prevent sexual abuse.</p> <p>4. Please refer to W331. The facility neglected for 2 of 4 sampled clients (clients A and B) to ensure the facility's nursing services met the health care needs of the clients in regard to assessing clients after documented incidents, neglected to ensure client A went for a follow up visit to his physician as recommended by the ER (Emergency Room)physician.</p> <p>This federal tag relates to complaint #IN00137327.</p> <p>9-3-1(a)</p>		<p>to be a false allegation. All direct supportstaff, QDDP, residential nurse, and residential house manager will be retrainedon Prohibition of Violation of Individual Rights policy (Appendix E) to ensurethat staff have a good understanding of the policy.Bona Vista is pursuing investigationtraining offered by Steve Corya in order to educate ourselves on theappropriate procedure to follow and to ensure compliance in the area ofinvestigations in the future. This training was originally scheduled for November 19, 2013, however, due tosignificant storm damage following a tornado in Kokomo, IN on November 17, 2013it was canceled. It is tentativelyrescheduled for December 10, 2013.Effective measures to preventalleged sexual abuse include HRC approval to leave all bedroom doors open atnight when consumers are sleeping to aid in supervision and ensure an extrameasure of safety. All consumers agree to this measure. Also, 15 minute bedchecks have been implemented and will be documented by midnight shift (AppendixB). All direct care staff, residentialnurse, residential house manager and QDDP will be trained on this process onNovember 26, 2013.The survey states that "thefacility</p>		

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			<p>neglected to ensure nursing services assessed clients after alleged incidents of sexual abuse". Medical care was immediately sought for the clients alleging sexual abuse. Clients A &amp; B were taken to Community Howard Hospital for an assessment by a physician. According to W318 Condition of Participation: Health Care Services, the Condition of Participation in Health Care Services is not met when individuals do not receive adequate health care monitoring and services, including appropriate and timely follow-up, based upon their individualized need for service". In this instance, the individualized need for services for these clients appeared to be emergency room service rather than assessment by residential nurse. This was based on the knowledge that if sexual abuse had occurred, specific testing procedures have to be followed in order to obtain evidence of abuse. Testing procedures used in these situations are not part of the nursing assessment/service that a group home nurse provides. The residential nurse did fail to ensure that Client A received follow up doctor appointment following emergency room visit. The residential nurse received corrective action for this oversight. Additionally, the ER follow up form was developed</p>		

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			(Appendix F) and isrequired to be completed by the residential nurse following an ER visit. Itdocuments all follow up care needed and also requires any lab work to befollowed up on. It will be completed bythe residential nurse within 48 hours of an ER visit and will be reviewed bythe Director of Residential Services. Itwill be filed in the consumer chart. To address adequate staff training,all staff will be trained on HRC approval to leave all bedroom doors open atnight when consumers are sleeping to aid in supervision and ensure an extrameasure of safety. All consumers agree to this measure. Also, 15 minute bedchecks have been implemented and will be documented by midnight staff (AppendixB). All direct care staff, residentialnurse, residential house manager, and QDDP will be trained on this process onNovember 26, 2013. 4. The survey states that "the facility neglectedto ensure the facilities nursing services met the health care needs of theclients in regard to assessing clients after documented incidents". Medical care was immediately sought for bothClients A & B. Both were taken toCommunity Howard Hospital for an assessment by a physician. Client B refusednurse assessment (pages 6-7 of 77 Survey Event ID Q8XJ11) but was willing to goto the ER. Client		

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			<p>A was immediately taken to Community Howard Hospital. According to W318 Condition of Participation: Health Care Services, the Condition of Participation in Health Care Services is not met when individuals do not receive adequate health care monitoring and services, including appropriate and timely follow-up, based upon their individualized need for service". In this instance, the individualized need for services for these clients appeared to be emergency room service rather than assessment by residential nurse. This was based on the knowledge that if sexual abuse had occurred, specific testing procedures have to be followed in order to obtain evidence of abuse. Testing procedures used in these situations are not part of the nursing assessment/service that a group home nurse provides. The residential nurse did fail to ensure that Client A received follow up doctor appointment following emergency room visit. The residential nurse received corrective action for this oversight. Additionally, the ER follow up form was developed (Appendix F) and is required to be completed by the residential nurse following an ER visit. It documents all follow up care needed and also requires any lab work to be followed up on. It will be completed by the residential</p>		

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			nurse within 48 hours of an ER visit and will be reviewed by the Director of Residential Services. It will be filed in the consumer chart.		

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W000104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review and interview, the governing body failed for 2 of 3 sampled clients (A and B) and 2 additional clients (D and H), to exercise general operating direction in a manner 1. to ensure the facility developed and implemented policy and procedures in regards to conducting thorough investigations and documentation of incident reports 2. to provide oversight to ensure their "Prohibition of Violations of Individual Rights" policy was implemented.</p> <p>Findings include:</p> <p>1. A review of the facility's Bureau of Developmental Disabilities Services reports (BDDS) and investigation records was conducted on 10/7/13 at 1:50 P.M.. Review of the reports indicated:</p> <p>-BDDS report dated 5/14/13: "At approximately 2:15 A.M. on 5/14 residential staff was completing nightly rounds. She observed [client H] in the bed of [client B]. Staff described that [client B]'s pants were down around his hips. [Client H] was nude and in back of [client B]. Staff stated that she saw</p>	W000104	<p>1. The agency policy related to conducting thorough investigations was updated in October 2013 and approved by the Bona Vista Board of Directors (Appendix C). All direct care staff, residential nurse, residential house manager and QDDP will be trained on the agency policy relating to conducting investigations. Investigation policy will be trained on annually (Appendix A). All direct care staff, residential nurse, residential house manager and QDDP will be retrained on Incident reporting (Appendix D) and all associated documentation on November 26, 2013. Emphasis will be placed on immediately documenting any allegations of ANE, and reporting the incident immediately to management. To ensure the "Prohibition of Violations of Individual Rights" policy (Organizational Section 04) (Appendix E) is understood and implemented, all staff will be trained on November 26, 2013 and will be retrained each November and May. This will be added to annual training schedule (Appendix A). Residential House Manager, QDDP, Director of Residential Services will be retrained on Bureau of Developmental Disabilities policy</p>	11/26/2013			

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	penetration and that penetration stopped when she came in to do her nightly check. Staff directed consumers back to their beds and observed interaction until consumers fell asleep. After consumers fell asleep, nightly checks were continued every 15 minutes. [Residential QDDP (Quality Developmental Disabilities Professional)] and [Residential House Manager (RHM)] were contacted. [Client B] was interviewed by [Director name], [Lead QDDP], (sic) and RHM regarding the incident. [Client B] initially stated that when he went (sic) bed he was listening to music and watching videos. [Client B] stated that he does not have good memory and that the rest of the night was blurry and he only remembered bits and pieces. [Client B] stated that the only thing he remembered was what staff had already documented. When asked to describe exactly what happened, [client B] stated that he couldn't remember. [Client H] was interviewed by Director, Lead QDDP, (sic) RHM, regarding this incident. [Client H] stated that [client B] asked him to 'screw him.' [Client H] stated he went to [client B's] bed at this time, (sic) and penetration occurred. [Client H] stated no kissing or other touching occurred and penetration lasted about 20 minutes and that this has never happened before. The Director and Lead QDDP interviewed [client B] again and		on Mandatory Components of an Investigation (Appendix F) on November 26, 2013. Additional training will be provided by Steve Corya tentatively scheduled for December 10, 2013. The survey states, "an observation was conducted at the group home on 10/8/13 from 2:55 a.m. until 5:15 a.m. During the entire observation period client H's bedroom door was closed". At the time of the observation, HRC approval had not been obtained to require that the door remain open. On October 29, 2013, that approval was obtained and the door is now open during sleep hours. The survey states that "the record did not have documentation to indicate any assessment of Client B by nursing". Client B refused nursing assessment but agreed to ER visit (pages 6-7 of 77 Survey Event ID Q8XJ11). He was taken to Community Howard Hospital for an assessment by a physician. According to W318 Condition of Participation: Health Care Services, the Condition of Participation in Health Care Services is not met when individuals do not receive adequate health care monitoring and services, including appropriate and timely follow-up, based upon their individualized need for service". In this instance, the individualized need for service for this client appeared to be emergency room service rather				

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	<p>asked him if he had thought about the incident anymore and if he had anything else he wanted to say. This author stated to him that the main concern was his safety. He then stated that [client H] asked to touch him and [client B] refused. [Client B] then stated that [client H] came to his bed and 'put his thing in me.' When asked why he didn't call for staff, he stated that he wanted to turn off his Ipod (radio) first...Plan to Resolve: [Client H] was taken to [Hotel name] with 2 staff for the night. [Client B] was taken to [Hospital name] for evaluation. This author contacted the police administrative number and it was answered by a voice mail. This author left a voice mail stating the situation and that [client B] was being taken to the hospital for evaluation. Staff transporting [client B] to [Hospital name] will inform hospital staff that a message regarding this allegation was left on the police administrative number voice mail."</p> <p>Review of investigation record for the 5/14/13 incident involving clients B and H indicated:</p> <p>"-5/14/13 @ (at) 2:15 A.M. residential staff was completing nightly rounds. DSP (Direct Support Professional) observed [client H] in the bed of [client B]. Staff described that [client B's] pants were down around his hips. [Client H] was</p>		<p>than assessment by residential nurse. This was based on the knowledge that if sexual abuse had occurred, specific testing procedures have to followed in order to obtain evidence of abuse. Testing procedures used in these situations are not part of the nursing assessment/service that a group home nurse provides.</p> <p>The residential nurse did fail to ensure that Client A received follow up doctor appointment following emergency room visit. The residential nurse received corrective action for this oversight. Additionally, the ER follow up form was developed (Appendix F) and is required to be completed by the residential nurse following an ER visit. It documents all follow up care needed and also requires any lab work to be followed up on. It will be completed by the residential nurse within 48 hours of an ER visit and will be reviewed by the Director of Residential Services. It will be filed in the consumer chart.</p> <p>The agency policy related to conducting thorough investigations was updated in October 2013 and approved by the Bona Vista Board of Directors (Appendix C). All direct care staff, residential nurse, residential house manager and QDDP will be trained on the agency policy relating to conducting investigations. Investigation policy will be trained</p>				

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	<p>nude and in back of [client B] Staff stated that she saw penetration and that penetration stopped when she came in to do her nightly check. Staff directed consumers back to their beds and observed interaction. After consumers were asleep, nightly checks were continued every 15 minutes. Residential QDDP and RHM were contacted immediately and directed DSP to monitor every 15 minutes.</p> <p>-5/14 @ 9:30 A.M. Residential Director (RD) was informed after consumers had gone to the workshop. RD instructed Lead QDDP to contact residential nurse to complete an assessment on [client B].</p> <p>-5/14 @ 4:00 P.M. [Client B] was interviewed by [Director], Lead QDDP, and (sic) RHM regarding this incident at approximately 4:00 P.M. [Client B] initially stated that when he went to bed he was listening to music and watching videos. [Client B] stated that he does not have good memory and that the rest of the night was blurry and he only remembered bits and pieces. [Client B] then stated that what he remembered was what staff already asked him and it was documented. When asked to describe exactly what happened, he stated that he couldn't remember. He refused to answer any more questions and left to go watch a</p>		<p>on annually (Appendix A). All direct care staff, residential nurse, residential house manager and QDDP will be retrained on Incident reporting (Appendix D) and all associated documentation on November 26, 2013. Emphasis will be placed on immediately documenting any allegations of ANE, and reporting the incident immediately to management.</p>		

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	<p>movie. [Nurse] reported to [Director] that [client B] refused an assessment.</p> <p>-[Client H] was interviewed by Director Lead QDDP, (sic) RHM, (sic) regarding this incident at approximately 4:30 P.M. [Client H] stated that [client B] asked him to 'screw him.' [Client H] stated he went to [client B]'s bed at this time, and penetration occurred. [Client H] stated no kissing or other touching occurred and that penetration lasted about 20 minutes and that this has never happened before.</p> <p>-At approximately 5:00 P.M., the Director and Lead QDDP interviewed [client B] again and asked him if he had thought about the incident anymore and if he had anything else he wanted to say. This author stated to him that the main concern was his safety. He then stated that [client H] asked to touch him and [client B] refused. [Client B] then stated [client H] came to his bed and 'put his thing in me.' When asked why he didn't call for staff, he stated that he wanted to turn off his Ipod first. [Director] asked [client B] if he would feel comfortable with an assessment by the residential nurse. He refused. When asked if he would be willing to go to the ER (Emergency Room) for an assessment he agreed.</p> <p>-At approximately 5:30 P.M., [Director],</p>				

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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>with the help of Lead QDDP began to arrange for staffing to take [client B] to [Hospital name] for an evaluation. Staffing arrangements were also made for [client H] to be taken to [Hotel name]for the evening. While arrangements were being made, [client B] and [client H] were in separate areas of the house and were being monitored by staff.</p> <p>-After arrangements were made and [client B] was being transported to the ER, [Director] called the [Police Department] at (sic) alert them of the situation. This was approximately 6:30 P.M.</p> <p>-5/14/13 @ 7:30 P.M., [client H] moved with staff to hotel to separate him from [client B].</p> <p>-5/14/13 @ 7:30 P.M., [Director] contacted [Guardian] to explain the incident between [client H] and [client B]. Informed [Guardian] that [client H] was being moved from home and that [client B] was being taken to ER by [DSP] for examination. [Guardian] gave verbal approval.</p> <p>-5/14/13 @ 9:28 P.M.-[Director] contacted [Guardian] to obtain verbal approval to complete rape kit at [Hospital name]. Informed [Guardian] of</p>				

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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901
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	<p>information received from ER nurse that unless some injury is found, [client B] will be able to go home shortly. Informed [Guardian] that unless he heard from me again that night, to assume that [client B] was fine and going home.</p> <p>-5/14/13 ER nurse informed [Director] that no visible sign of penetration was noted and no injury present. Nothing internal was noted either. Rape kit was completed and will be sent to police. ER doctor interviewed [client B] who denied any sexual activity with [client H].</p> <p>-5/14/13 [Director] spoke to [Officer name]. [Director] informed police that both individuals have guardians and that any investigation would need to be completed via guardians. Police stated that after obtaining results of the rape kit, the case would be handed over to a detective who would contact [Director] for information on guardians (phone numbers). [Case number].</p> <p>-[Director] instructed staff to complete bedchecks every 15 minutes instead of every hour.</p> <p>-5/14/13 [Director] spoke to Lead QDDP who stated she had informed [client H]'s guardian at 7:30 P.M. and would call her in the morning with an update.</p>			

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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901			
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	<p>-5/14/13-10:06 P.M. [Director] called [BDDS Coordinator] and left message .</p> <p>-5/15/13-7:47 A.M. [BDDS Coordinator] called [Director] and [Director] updated him on situation. [Director] asked for [BDDS Coordinator]'s opinion on moving [client H] to another house. [BDDS Coordinator] was okay with that if there were no other options.</p> <p>-5/15/13-[Director] at Workshop at 8:00 A.M. to instruct staff to 1:1 (one staff with client) with [client H] until further notice.</p> <p>-5/15/13-Emergency IDT (Inter Disciplinary Team) meeting to discuss issue. Documentation from meeting saved on separate file.</p> <p>-On 5/17/13 [Director] received call from [Officer] saying there wasn't enough evidence to pursue the case. [Client B] had changed his stories and was non-committal about what happened between them. Additionally, there was no physical evidence of any penetration.</p> <p>-5/17/13-[Director] called [BDDS Coordinator] to update on police report. Reported that [client H] was still staying in a hotel.</p>						

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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901			
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	<p>-[Director] asked staff at house if [client B's] father had called him since the incident. Staff reported no.</p> <p>-5/17/13-[Director] talked to [BDDS Coordinator] about [client H] staying at another group home over the weekend if staff were trained. [BDDS Coordinator] gave approval. Staff was trained and documentation sent to HR (Human Resources).</p> <p>-5/21/13 at 8:50 A.M.-[Director] called [Guardian] to update him on police decision. [Guardian] has never initiated contact with [Director] up to this point to inquire about status. [Guardian] was upset that [Agency name] was considering moving [client H] back into the group home.</p> <p>-5/21/13 at 4:14 P.M. [Director] called [BDDS Coordinator] to discuss moving back [client H] back into home. [BDDS Coordinator] thought that it was appropriate as long as [client H] and [client B] weren't sharing a bedroom.</p> <p>-5/22/13-[Director] called the guardian of a consumer at [Group Home #2] to discuss possibly switching the two. She was not in agreement.</p>						

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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901			
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	<p>-5/23/13-sent e mail (electronic) to IDT (saved separate file) stating plan to move [client H] back into home, to switch bedrooms and continue 15 minute bed checks. [Staff name] inquired about putting a door alarm on the bedroom but [Director] didn't feel that [client H's] roommate would agree.</p> <p>-5/23/13 at 11/23/13 [BDDS Coordinator] called [Director] to tell her that he had talked to [Guardian] who stated he wanted to move [client B]. [BDDS Coordinator] explained the process to [Guardian] who became angry. [BDDS Coordinator] asked [Director] to send recent physical with diagnosis for [client B]. [Director] emailed on 5/24/13.</p> <p>-5/24/13 staff rearranged bedrooms in the home so that [client B] and [client H] were no longer sharing a bedroom. [Client H] was returned to the home (from hotel).</p> <p>An email record dated 5/23/13 indicated: "Importance: High: Wanted to update you on the situation. I have been in regular contact with [BDDS Coordinator] regarding [client H] and [client B]. It is [BDDS Coordinator]'s opinion, that [client H] is okay to move back to [Group home name] with the following measures: he no longer share a bedroom with [client</p>						

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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901			
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	<p>B], that staff continue nightly bedchecks every 30 minutes instead of 1 hour and that adequate staffing is present in the home. If you remember from our IDT, in order to move [client H] back to [Group Home #2], [Group home #2 client] would need to be moved and his guardian would need to give consent. [Group home #2 client]'s guardian is NOT in agreement. Without guardian agreement, we cannot move forward with moving him. Based on that, and with [BDDS Coordinator's] input above, we are planning to move [client H] back to [Group Home name]. He will be moved into the bedroom directly across from the staff office and he will be rooming with [client E]. The measures listed above have been implemented...."</p> <p>Further review of the investigation record did not indicate all clients who resided at the group home and all staff who worked at the group home were interviewed. Review of the record did not indicate the investigation was completed in 5 working days. The record did not indicate the administrator was immediately notified of the incident. The record did not have the police report for the incident. The report did not have the lab results from the hospital.</p> <p>An observation was conducted at the</p>						

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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901
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	<p>group home on 10/8/13 from 2:55 A.M. until 5:15 A.M.. During the entire observation period client H's bedroom door was closed.</p> <p>A review of client B's record was conducted on 10/8/13 at 9:50 A.M.. A review of the record indicated: "[Hospital name] Patient Discharge Instructions'...Current Date 5/14/13...Nursing Reason for Visit; Patient Stated Complaint: Sexual assault victim; RAPE Victim...Follow-Up Instructions: Follow up with primary care provider...Sexual Assault Exam: You have had an exam today because of a sexual assault. The purpose of this exam is to -Find out if you have any injuries that need treatment -Offer treatment to prevent gonorrhea and chlamydia infections (commonly transmitted diseases) -Offer treatment to prevent HIV infection -Arrange for follow up counseling FOLLOW UP with your doctor for continued medical care."</p> <p>The record did not have documentation to indicate any assessments of client B by nursing services. The record did not indicate any results from client B's hospital visit.</p>			

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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901
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	<p>A request for staff training documentation was made on 10/8/13 @ 11:00 A.M..</p> <p>Review of the documentation submitted for review indicated: "Residential Staff Meeting" [Group home name] 6/12/13...Staff Present: [DSP #1], [DSP #2], [DSP #3], [DSP #4], [DSP #5]...Staff Absent: [DSP #6], [DSP #7], [DSP #8], [DSP #9], [DSP #10]...Documentation Errors-Review policy: RHM reviewing program goals daily, QDDP's reviewing daily notes 1x (one time) each week, Errors are being tracked and documented...Medication Administration Policy Reviewed: Staff signature that they understand medication admin policy...Money Policy reviewed: Staff signature on Residential money policy...Midnight cleaning checklist-cleaning is everyone's responsibility...Calling QDDP and RHM-on call procedure...Review risk plans-staff initial...1x week pop cans." Review of the record did not indicate all group home staff were trained on doing bed checks every 1/2 hour or 15 minutes.</p> <p>A review of the facility's records was conducted on 10/8/13 at 10:30 A.M.. Review of the group home "Consumer Nightly Check Records" dated 5/1/13 to 10/13 indicated: "STAFF ARE TO CHECK ON EACH INDIVIDUAL EVERY HOUR AS SPECIFIED. Staff</p>			

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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>are to open each bedroom door every hour to observe consumer breathing and any device that may be used to see if it is working properly. Be sure documentation is accurate. Staff will document as they check on each consumer. If the supervising staff come in and the documentation is not being completed, disciplinary action will result." Review of each monthly record documentation indicated bed checks were conducted every hour. The record did not indicate bedchecks were conducted every 15 minutes or every 30 minutes.</p> <p>2. A review of the facility's Bureau of Developmental Disabilities Services reports (BDDS) and investigation records was conducted on 10/7/13 at 1:50 P.M.. Review of the reports indicated:</p> <p>-BDDS report dated 9/26/13: "On Sept. 27, 2013 at 11:45 A.M. [client A] reported to his workshop supervisor [Supervisor name] that on Sept. 26, 2013 [client D] raped him. [Client A] reported that this incident happened at the group home. [Client D] was interviewed by QDDP (Qualified Developmental Disabilities Professional) and [Social Service Director]. [Client D] denied the allegations...Plan to Resolve: [Client A] and [client D] are monitored 24 hours by staff for safety. [Client A] was taken to</p>			

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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>[Hospital name] for evaluation. [Client A]'s guardian has been contacted about this incident. [Client A] and [client D] will be staff (sic) in separate rooms at the group home."</p> <p>Review of the investigation record for the 9/26/13 incident involving clients A and D indicated: "[Client A]'s initial story was that [client D] raped him, however, in the course of being interviewed by his QDDP, [client A]'s story changed to it being a consensual act. He then started talking about babies in his stomach and feeling things kick in his belly. [Client D] denied any contact between him and [client A] that night and staff on daily notes and sleep documentation support [client D]'s story. The ER doctor completed an anal exam on [client A] who had not showered since the reported incident. He found no injury, abrasion, tears, or evidence of sexual activity. Because of inconsistency in [client A]'s story, and lack of supporting evidence, it does not appear that [client A] was raped or that any contact occurred. [Client A] has a history of fabricating and of delusional talk. Earlier in the week, he had attempted to elope several times and his QDDP was describing the dangers of him wandering by himself. During that discussion, [client A] asked her what kinds of dangerous things could happen.</p>			

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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>She talked about rape at that time. Shortly after that discussion [client A] made the allegation. [Client A]'s guardian was satisfied with switching bedrooms to minimize contact between [client D] and [client A]. He did not wish to pursue police involvement." Further review of the record indicated the two scheduled overnight staff and clients A and D were the only persons interviewed. The record indicated:</p> <p>"Interview with [client D], consumer and QDDP and Director of Habilitation and Social Services (DHSS) on 9/27/13 at 2:30 P.M.:</p> <p>QDDP: 'How was your night? Did you sleep okay?' Client D: Nodded yes QDDP: 'The medicine keeping you awake?' Client D: 'Yea' QDDP: 'It's keeping you awake?' Client D: 'No' QDDP: 'So you slept all night?' Client D: 'No.' Client D pointed to his arm and said 'a tear in my arm forced me up all night.' QDDP: 'Do you ever get up and get you and [client A] a snack?' Client D: 'No, we got motivated.' QDDP: 'Did he wake you up?' Client D: 'I woke myself up.'</p>			

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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901
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	<p>QDDP: 'During the night, did he wake you up?' Client D: 'No. My pants and shirt got something on me.' QDDP: 'What?' Client D: 'White stuff.' QDDP: 'What do you do when you are up?' Client D: 'Normally we play the Wii (video game) and watch movies.' QDDP: 'What kind of movies do you watch?' Client D: 'Funny ones and inappropriate ones.'</p> <p>Interview with [client A] and Director 9/27/13 at 2:30 P.M.. indicated:</p> <p>"Director: 'Can you tell me what happened?' Client A: '[Client D] had sex with me.' Director: 'Describe what happened.' Client A: 'He put his [penis] in my [anus].' Director: 'Did you ask him to?' Client A: 'No.' Director: 'Did you call staff to come and help you?' Client A: 'No.' Director: 'Did it last a long time?' Client A: 'No. He put it in and pulled it out.' Director: 'One time?' Client A: 'Yes'</p>			

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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901			
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	<p>Director: 'Then what did you do?' Client A: 'I tried to put my [penis] in his [anus] but it didn't work.' Director: 'Was this something you wanted to do and were embarrassed about, or did he hurt you?' Client A: 'I was feeling frisky. Now I have a baby in my stomach. I can feel it kick.'"</p> <p>A review of client A's record was conducted on 10/8/13 at 9:50 A.M.. Review of client A's record indicated: "Patient Discharge Instructions...Current Date: 9/27/13...Name: [Client A]...Follow-up Instructions: Follow up with primary care provider." Review of client A's record did not indicate he followed up with his primary care provider as recommended by the ER physician and did not indicate any testing or examinations had been conducted while at the ER. The record did not indicate the facility's nursing staff assessed client A after the incident.</p> <p>A review of the facility's "Prohibition of Violations of Individual Rights" policy no date noted was conducted on 10/7/13 at 2:17 P.M. and indicated: "In order to protect the general welfare of persons served, Bona Vista Programs strictly prohibits the abuse of any form, neglect, exploitation or mistreatment of an</p>						

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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901
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	<p>individual or violation of an individual's rights by employees or agents delivering services on behalf of the agency.</p> <p>Definitions: Abuse: Intentional willful infliction of physical injury; unnecessary physical or chemical restraints, or isolation; punishment resulting with physical harm or pain; sexual molestation, rape, sexual misconduct, sexual coercion, and sexual exploitation...Neglect: Failure to provide supervision, training, appropriate care, food, medical care, or medical supervision to an individual...Reporting: It is the responsibility of any employee who possesses knowledge of an alleged case of neglect, battery, exploitation or violation of individual rights to report it immediately, verbally and/or in writing to the President or, if the President is unavailable, the Director, Human Resources." The policy did not include how the facility was to conduct thorough investigations to rule out abuse and neglect. The policy did not include how staff were to document incidents.</p> <p>An interview with the Director was conducted on 10/8/13 at 11:10 A.M.. When asked if there was documentation to indicate the administrator was notified of the mentioned incidents, the Director stated "No." When asked if the investigation for the 5/14/13 incident had</p>			

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	<p>been completed within 5 working days, the Director stated "No." When asked if there was documentation to indicate the facility's nursing services had completed assessments of the clients after the incidents, the Director stated "No." When asked if there was documentation to indicate all group home staff had training on bedchecks and documentation, the Director stated "No." When asked how often staff were to do and document bed checks at the group home, the Director stated "Every 30 minutes." When asked if there was documentation to indicate staff completed bed checks every 30 minutes, the Director stated "No, the documentation shows bed checks are done every hour." When asked if client A had followed up with his primary care physician as recommended by the ER physician, the Director stated "No he has not."</p> <p>This federal tag relates to complaint #IN00137327.</p> <p>9-3-1(a)</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  10/31/2013	
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W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview and record review, the governing body failed to ensure the facility met the Condition of Participation: Client Protections for 2 of 4 sampled clients )a and B) and 2 additional clients (D and H). The governing body failed to implement its written policies and procedures to prevent abuse of clients in regard to sexual abuse. The facility failed to put in place sufficient/effective corrective measures to prevent the potential of sexual abuse, failed to conduct thorough investigations, failed to provide staff with training to conduct bed checks to prevent potential sexual abuse and failed to ensure nursing care was provided after sexual abuse.</p> <p>Findings include:</p> <p>1. Please refer to W149: The facility neglected for 2 of 4 sampled clients (A and B) and 2 additional clients (D and H) to implement written policy and procedures to prevent alleged sexual abuse. The facility neglected to conduct thorough investigations in regards to alleged sexual abuse. The facility neglected to put in place effective measures to prevent alleged sexual abuse. The facility neglected to ensure nursing</p>	W000122	<p>1. All direct care staff, residential nurse, residential house manager and QDDP will be retrained on DDRS guidelines related to Abuse, Neglect and Exploitation on November 26, 2013. This training is done annually for all staff as part of BDDS policy training. A second training will be added to the training schedule (Appendix A) to ensure that all staff are trained twice annually. This extra training is important to emphasize the seriousness of the topic and to serve as a reminder of the policy for dealing with allegations. The agency policy related to conducting thorough investigations was updated in October 2013 and approved by the Bona Vista Board of Directors (Appendix C). All direct care staff, residential nurse, residential house manager and QDDP will be trained on the agency policy relating to conducting investigations. Investigation policy will be trained on annually (Appendix A). HRC approval was obtained to leave all bedroom doors open at night when consumers are sleeping to aid in supervision and ensure an extra measure of safety. All consumers agree to this measure. 15 minute bed checks have been implemented and will be</p>	11/26/2013			

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	<p>services assessed clients after alleged incidents of sexual abuse and to ensure staff were adequately trained to provide supervision of clients to prevent sexual abuse.</p> <p>2. Please refer to W154: The facility failed to provide written evidence a thorough investigations were conducted for 2 of 2 incidents, involving 2 of 4 sampled clients and 2 additional clients</p> <p>3. Please refer to W157: The facility failed to take appropriate corrective measures and/or provide retraining in regard to allegations of sexual abuse involving clients A, B, D and H.</p> <p>This federal tag relates to complaint #IN00137327.</p> <p>9-3-2(a)</p>		<p>documented by midnight shift (Appendix B). All direct care staff, residential nurse, residential house manager and QDDP will be trained on this process on November 26, 2013. Client D and H were not assessed by the residential nurse. The agency investigation policy adopted October 2013 (Appendix B) clearly indicates providing appropriate care or services. The Residential nurse will be trained on the agency investigation policy on November 26, 2013.</p> <p>Client A (separate incident) was immediately taken to Community Howard Regional for medical care. The reason for this was that the individualized need for service for this client appeared to be emergency room service rather than assessment by residential nurse. This was based on the knowledge that if sexual abuse had occurred, specific testing procedures have to followed in order to obtain evidence of abuse. Testing procedures used in these situations are not part of the nursing assessment/service that a group home nurse provides. Client B refused a nursing assessment but agreed to go to the Emergency Room and was assessed there (Survey page 6-7 of 77). 2. Residential House Manager, QDDP, Director of Residential Services will be retrained on Bureau of Developmental Disabilities policy</p>		

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			on Mandatory Components of an Investigation, to include appropriatedocumentation on November 26, 2013 (Appendix E). Additional training will beprovided by Steve Corya tentatively scheduled for December 10, 2013. 3. The Consumer Nightly Check sheet has beenrevised to require routine monitoring every 15 minutes during sleeping hours(Appendix B). All staff will be trainedin this new policy on November 26, 2013. Additionally, HRC approval was given to require bedroom doors remain openduring sleep hours.	

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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review, observation and interview for 4 of 8 clients residing at the group home (clients A, B, D and H) the facility neglected to implement written policy and procedures to prevent alleged sexual abuse. The facility neglected to conduct thorough investigations in regards to alleged sexual abuse. The facility neglected to put in place effective measures to prevent alleged sexual abuse. The facility neglected to ensure nursing services assessed clients after alleged incidents of sexual abuse and to ensure staff were adequately trained to provide supervision of clients to prevent sexual abuse.</p> <p>Findings include:</p> <p>1. A review of the facility's Bureau of Developmental Disabilities Services reports (BDDS) and investigation records was conducted on 10/7/13 at 1:50 P.M. Review of the reports indicated:</p> <p>-BDDS report dated 5/14/13: "At approximately 2:15 A.M. on 5/14 residential staff was completing nightly rounds. She observed [client H] in the bed of [client B]. Staff described that</p>	W000149	All direct care staff, residential nurse, residential house manager and QDDP will be retrained on DDRS guidelines related to Abuse, Neglect and Exploitation on November 26, 2013. This training is done annually for all staff as part of BDDS policy training. A second training will be added to the training schedule (Appendix A) to ensure that all staff are trained twice annually. This extra training is important to emphasize the seriousness of the topic and to serve as a reminder of the policy for dealing with allegations. All direct care staff, residential nurse, residential house manager and QDDP will be retrained on Incident reporting and all associated documentation on November 26, 2013. To ensure the "Prohibition of Violations of Individual Rights" policy (Organizational Section 04) is understood and implemented, all staff will be trained on November 26, 2013 and will be retrained each November and May. This will be added to annual training schedule (Appendix A). The agency policy related to conducting thorough investigations was updated in October 2013 and approved by the Bona Vista Board of Directors	11/26/2013	

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	[client B's] pants were down around his hips. [Client H] was nude and in back of [client B]. Staff stated that she saw penetration and that penetration stopped when she came in to do her nightly check. Staff directed consumers back to their beds and observed interaction until consumers fell asleep. After consumers fell asleep, nightly checks were continued every 15 minutes. [Residential QDDP (Quality Developmental Disabilities Professional)] and [Residential House Manager (RHM)] were contacted. [Client B] was interviewed by [Director name], [Lead QDDP], (sic) and RHM regarding the incident. [Client B] initially stated that when he went (sic) bed he was listening to music and watching videos. [Client B] stated that he does not have good memory and that the rest of the night was blurry and he only remembered bits and pieces. [Client B] stated that the only thing he remembered was what staff had already documented. When asked to describe exactly what happened, [client B] stated that he couldn't remember. [Client H] was interviewed by Director, Lead QDDP, (sic) RHM, regarding this incident. [Client H] stated that [client B] asked him to 'screw him.' [Client H] stated he went to [client B's] bed at this time, (sic) and penetration occurred. [Client H] stated no kissing or other touching occurred and penetration lasted		(Appendix C). All direct care staff, residential nurse, residential house manager and QDDP will be trained on the agency policy relating to conducting investigations. Investigation policy will be trained on annually (Appendix A). The survey states, "an observation was conducted at the group home with clients A, B, C, D, E, F, G, and H, on 10/8/13 from 2:55 a.m. until 5:15 a.m. During the entire observation period client H's bedroom door was closed". At the time of the observation, HRC approval had not been obtained to require that the door remain open. On October 29, 2013, that approval was obtained and the door is now open during sleep hours. The survey states that the record did not have documentation to indicate any assessments of client B by nursing staff, however, documentation states that Client B refused a nursing assessment, however, agreed to an emergency room visit for assessment (Page 7 of 77 State Survey Event ID Q8XJ11). The Consumer Nightly Check sheet has been revised to require routine monitoring every 15 minutes during sleeping hours (Appendix B). All staff will be trained in this policy on November 26, 2013. Additionally, HRC approval was given to require bedroom doors remain open during sleep hours. The		

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	<p>about 20 minutes and that this has never happened before. The Director and Lead QDDP interviewed [client B] again and asked him if he had thought about the incident anymore and if he had anything else he wanted to say. This author stated to him that the main concern was his safety. He then stated that [client H] asked to touch him and [client B] refused. [Client B] then stated that [client H] came to his bed and 'put his thing in me'. When asked why he didn't call for staff, he stated that he wanted to turn off his Ipod (radio) first...Plan to Resolve: [Client H] was taken to [Hotel name] with 2 staff for the night. [Client B] was taken to [Hospital name] for evaluation. This author contacted the police administrative number and it was answered by a voice mail. This author left a voice mail stating the situation and that [client B] was being taken to the hospital for evaluation. Staff transporting [client B] to [Hospital name] will inform hospital staff that a message regarding this allegation was left on the police administrative number voice mail."</p> <p>Review of investigation record for the 5/14/13 incident involving clients B and H indicated:</p> <p>"-5/14/13 @ (at) 2:15 A.M. residential staff was completing nightly rounds. DSP (Direct Support Professional) observed</p>		<p>residential nurse did fail to ensure that Client A received follow up doctor appointment following emergency room visit. The residential nurse received corrective action for this oversight. Additionally, the ER follow up form was developed (Appendix D) and is required to be completed by the residential nurse following an ER visit. It documents all follow up care needed and also requires any lab work to be followed up on. It will be completed by the residential nurse within 48 hours of an ER visit and will be reviewed by the Director of Residential Services. It will be filed in the consumer chart. The survey states, "the record did not indicate the facility's nurse assessed Client A after the incident". Medical care was immediately sought for the client alleging sexual abuse. He was taken to Community Howard Hospital for an assessment by a physician. According to W318 Condition of Participation: Health Care Services, the Condition of Participation in Health Care Services is not met when individuals do not receive adequate health care monitoring and services, including appropriate and timely follow-up, based upon their individualized need for service". In this instance, the individualized need for services for this client appeared to be emergency room service rather than</p>				

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	<p>[client H] in the bed of [client B]. Staff described that [client B]'s pants were down around his hips. [Client H] was nude and in back of [client B] Staff stated that she saw penetration and that penetration stopped when she came in to do her nightly check. Staff directed consumers back to their beds and observed interaction. After consumers were asleep, nightly checks were continued every 15 minutes. Residential QDDP and RHM were contacted immediately and directed DSP to monitor every 15 minutes.</p> <p>-5/14 @ 9:30 A.M. Residential Director (RD) was informed after consumers had gone to the workshop. RD instructed Lead QDDP to contact residential nurse to complete an assessment on [client B].</p> <p>-5/14 @ 4:00 P.M. [Client B] was interviewed by [Director], Lead QDDP, and (sic) RHM regarding this incident at approximately 4:00 P.M. [Client B] initially stated that when he went to bed he was listening to music and watching videos. [Client B] stated that he does not have good memory and that the rest of the night was blurry and he only remembered bits and pieces. [Client B] then stated that what he remembered was what staff already asked him and it was documented. When asked to describe exactly what</p>		<p>assessment by residential nurse. This was based on the knowledge that if sexual abuse had occurred, specific testing procedures have to followed in order to obtain evidence of abuse. Testing procedures used in these situations are not part of the nursing assessment/service that a group home nurse provides. The survey states, "when asked if there was documentation to indicate the administrator was notified of the mentioned incidents, the Director stated No", however the director provided documentation of the interview she conducted with Client A within 2.5 hours of the allegation being made (Appendix H). Residential House Manager, QDDP, Director of Residential Services will be retrained on Bureau of Developmental Disabilities policy on Mandatory Components of an Investigation on November 26, 2013. Additional training will be provided by Steve Corya tentatively scheduled for December 10, 2013. The Consumer Nightly Check sheet has been revised to require routine monitoring every 15 minutes during sleeping hours (Appendix B). All staff will be retrained in this new policy on November 26, 2013. Additionally, HRC approval was given to require bedroom doors remain open during sleep hours. The residential nurse did fail to ensure</p>				

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	<p>happened, he stated that he couldn't remember. He refused to answer any more questions and left to go watch a movie. [Nurse] reported to [Director] that [client B] refused an assessment.</p> <p>-[Client H] was interviewed by Director Lead QDDP, (sic) RHM, (sic) regarding this incident at approximately 4:30 P.M.. [Client H] stated that [client B] asked him to 'screw him.' [Client H] stated he went to [client B]'s bed at this time, and penetration occurred. [Client H] stated no kissing or other touching occurred and that penetration lasted about 20 minutes and that this has never happened before.</p> <p>-At approximately 5:00 P.M., the Director and Lead QDDP interviewed [client B] again and asked him if he had thought about the incident anymore and if he had anything else he wanted to say. This author stated to him that the main concern was his safety. He then stated that [client H] asked to touch him and [client B] refused. [Client B] then stated [client H] came to his bed and 'put his thing in me'. When asked why he didn't call for staff, he stated that he wanted to turn off his Ipod first. [Director] asked [client B] if he would feel comfortable with an assessment by the residential nurse. He refused. When asked if he would be willing to go to the ER (Emergency</p>		<p>that the alleged victim received follow up doctor appointment following emergency room visit. The residential nurse received corrective action for this oversight. Additionally, the ER follow up form was developed (Appendix D) and is required to be completed by the residential nurse following an ER visit. It documents all follow up care needed and also requires any lab work to be followed up on. It will be completed by the residential nurse within 48 hours of an ER visit and will be reviewed by the Director of Residential Services. It will be filed in the consumer chart.</p>	

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	<p>Room) for an assessment he agreed.</p> <p>-At approximately 5:30 P.M., [Director], with the help of Lead QDDP began to arrange for staffing to take [client B] to [Hospital name] for an evaluation. Staffing arrangements were also made for [client H] to be taken to [Hotel name]for the evening. While arrangements were being made, [client B] and [client H] were in separate areas of the house and were being monitored by staff.</p> <p>-After arrangements were made and [client B] was being transported to the ER, [Director] called the [Police Department] at (sic) alert them of the situation. This was approximately 6:30 P.M.</p> <p>-5/14/13 @ 7:30 P.M., [client H] moved with staff to hotel to separate him from [client B].</p> <p>-5/14/13 @ 7:30 P.M., [Director] contacted [Guardian] to explain the incident between [client H] and [client B]. Informed [Guardian] that [client H] was being moved from home and that [client B] was being taken to ER by [DSP] for examination. [Guardian] gave verbal approval.</p> <p>-5/14/13 @ 9:28 P.M.-[Director]</p>						

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	<p>contacted [Guardian] to obtain verbal approval to complete rape kit at [Hospital name]. Informed [Guardian] of information received from ER nurse that unless some injury is found, [client B] will be able to go home shortly. Informed [Guardian] that unless he heard from me again that night, to assume that [client B] was fine and going home.</p> <p>-5/14/13 ER nurse informed [Director] that no visible sign of penetration was noted and no injury present. Nothing internal was noted either. Rape kit was completed and will be sent to police. ER doctor interviewed [client B] who denied any sexual activity with [client H].</p> <p>-5/14/13 [Director] spoke to [Officer name]. [Director] informed police that both individuals have guardians and that any investigation would need to be completed via guardians. Police stated that after obtaining results of the rape kit, the case would be handed over to a detective who would contact [Director] for information on guardians (phone numbers). [Case number].</p> <p>-[Director] instructed staff to complete bedchecks every 15 minutes instead of every hour.</p> <p>-5/14/13 [Director] spoke to Lead QDDP</p>			

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	<p>who stated she had informed [client H]'s guardian at 7:30 P.M. and would call her in the morning with an update.</p> <p>-5/14/13-10:06 P.M. [Director] called [BDDS Coordinator] and left message .</p> <p>-5/15/13-7:47 A.M. [BDDS Coordinator] called [Director] and [Director] updated him on situation. [Director] asked for [BDDS Coordinator's] opinion on moving [client H] to another house. [BDDS Coordinator] was okay with that if there were no other options.</p> <p>-5/15/13-[Director] at Workshop at 8:00 A.M. to instruct staff to 1:1 (one staff with client) with [client H] until further notice.</p> <p>-5/15/13-Emergency IDT (Inter Disciplinary Team) meeting to discuss issue. Documentation from meeting saved on separate file.</p> <p>-On 5/17/13 [Director] received call from [Officer] saying there wasn't enough evidence to pursue the case. [Client B] had changed his stories and was non-committal about what happened between them. Additionally, there was no physical evidence of any penetration.</p> <p>-5/17/13-[Director] called [BDDS</p>			

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	<p>Coordinator] to update on police report. Reported that [client H] was still staying in a hotel.</p> <p>-[Director] asked staff at house if [client B's] father had called him since the incident. Staff reported no.</p> <p>-5/17/13-[Director] talked to [BDDS Coordinator] about [client H] staying at another group home over the weekend if staff were trained. [BDDS Coordinator] gave approval. Staff was trained and documentation sent to HR (Human Resources).</p> <p>-5/21/13 at 8:50 A.M.-[Director] called [Guardian] to update him on police decision. [Guardian] has never initiated contact with [Director] up to this point to inquire about status. [Guardian] was upset that [Agency name] was considering moving [client H] back into the group home.</p> <p>-5/21/13 at 4:14 P.M. [Director] called [BDDS Coordinator] to discuss moving back [client H] back into home. [BDDS Coordinator] thought that it was appropriate as long as [client H] and [client B] weren't sharing a bedroom.</p> <p>-5/22/13-[Director] called the guardian of a consumer at [Group Home #2] to</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  10/31/2013	
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>discuss possibly switching the two. She was not in agreement.</p> <p>-5/23/13-sent e mail (electronic) to IDT (saved separate file) stating plan to move [client H] back into home, to switch bedrooms and continue 15 minute bed checks. [Staff name] inquired about putting a door alarm on the bedroom but [Director] didn't feel that [client H's] roommate would agree.</p> <p>-5/23/13 at 11/23/13 [BDDS Coordinator] called [Director] to tell her that he had talked to [Guardian] who stated he wanted to move [client B]. [BDDS Coordinator] explained the process to [Guardian] who became angry. [BDDS Coordinator] asked [Director] to send recent physical with diagnosis for [client B]. [Director] emailed on 5/24/13.</p> <p>-5/24/13 staff rearranged bedrooms in the home so that [client B] and [client H] were no longer sharing a bedroom. [Client H] was returned to the home (from hotel)."</p> <p>An email record dated 5/23/13 indicated: "Importance: High: Wanted to update you on the situation. I have been in regular contact with [BDDS Coordinator] regarding [client H] and [client B]. It is [BDDS Coordinator]'s opinion, that</p>						

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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901
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	<p>[client H] is okay to move back to [Group home name] with the following measures: he no longer share a bedroom with [client B], that staff continue nightly bedchecks every 30 minutes instead of 1 hour and that adequate staffing is present in the home. If you remember from our IDT, in order to move [client H] back to [Group Home #2], [Group home #2 client] would need to be moved and his guardian would need to give consent. [Group home #2 client]'s guardian is NOT in agreement. Without guardian agreement, we cannot move forward with moving him. Based on that, and with [BDDS Coordinator's] input above, we are planning to move [client H] back to [Group Home name]. He will be moved into the bedroom directly across from the staff office and he will be rooming with [client E]. The measures listed above have been implemented...."</p> <p>Further review of the investigation record did not indicate all clients who resided at the group home and all staff who worked at the group home were interviewed. Review of the record did not indicate the investigation was completed in 5 working days. The record did not indicate the administrator was immediately notified of the incident. The record did not have the police report for the incident. The report did not have the lab results from the</p>			

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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901			
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	<p>hospital.</p> <p>An observation was conducted at the group home with clients A, B, C, D, E, F, G and H on 10/8/13 from 2:55 A.M. until 5:15 A.M. During the entire observation period client H's bedroom door was closed.</p> <p>A review of client B's record was conducted on 10/8/13 at 9:50 A.M. A review of the record indicated: "[Hospital name] Patient Discharge Instructions'...Current Date 5/14/13...Nursing Reason for Visit; Patient Stated Complaint: Sexual assault victim; RAPE Victim...Follow-Up Instructions: Follow up with primary care provider...Sexual Assault Exam: You have had an exam today because of a sexual assault. The purpose of this exam is to -Find out if you have any injuries that need treatment -Offer treatment to prevent gonorrhea and chlamydia infections (commonly transmitted diseases) -Offer treatment to prevent HIV infection -Arrange for follow up counseling FOLLOW UP with your doctor for continued medical care."</p> <p>The record did not have documentation to indicate any assessments of client B by</p>						

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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901			
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	<p>nursing services. The record did not indicate any results from client B's hospital visit.</p> <p>A request for staff training documentation was made on 10/8/13 @ 11:00 A.M. Review of the documentation submitted for review indicated: "Residential Staff Meeting" [Group home name] 6/12/13...Staff Present: [DSP #1], [DSP #2], [DSP #3], [DSP #4], [DSP #5]...Staff Absent: [DSP #6], [DSP #7], [DSP #8], [DSP #9], [DSP #10]...Documentation Errors-Review policy: RHM reviewing program goals daily, QDDP's reviewing daily notes 1x (one time) each week, Errors are being tracked and documented...Medication Administration Policy Reviewed: Staff signature that they understand medication admin policy...Money Policy reviewed: Staff signature on Residential money policy...Midnight cleaning checklist-cleaning is everyone's responsibility...Calling QDDP and RHM-on call procedure...Review risk plans-staff initial...1x week pop cans." Review of the record did not indicate all group home staff were trained on doing bed checks every 1/2 hour or 15 minutes.</p> <p>A review of the facility's records was conducted on 10/8/13 at 10:30 A.M. Review of the group home "Consumer</p>						

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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901
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	<p>Nightly Check Records" dated 5/1/13 to 10/13 indicated: "STAFF ARE TO CHECK ON EACH INDIVIDUAL EVERY HOUR AS SPECIFIED. Staff are to open each bedroom door every hour to observe consumer breathing and any device that may be used to see if it is working properly. Be sure documentation is accurate. Staff will document as they check on each consumer. If the supervising staff come in and the documentation is not being completed, disciplinary action will result." Review of each monthly record documentation indicated bed checks were conducted every hour. The record did not indicate bedchecks were conducted every 15 minutes or every 30 minutes.</p> <p>2. A review of the facility's Bureau of Developmental Disabilities Services reports (BDDS) and investigation records was conducted on 10/7/13 at 1:50 P.M. Review of the reports indicated:</p> <p>-BDDS report dated 9/26/13: "On Sept. 27, 2013 at 11:45 A.M. [client A] reported to his workshop supervisor [Supervisor name] that on Sept. 26, 2013 [client D] raped him. [Client A] reported that this incident happened at the group home. [Client D] was interviewed by QDDP (Qualified Developmental Disabilities Professional) and [Social</p>			

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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901
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	<p>Service Director]. [Client D] denied the allegations...Plan to Resolve: [Client A] and [client D] are monitored 24 hours by staff for safety. [Client A] was taken to [Hospital name] for evaluation. [Client A's] guardian has been contacted about this incident. [Client A] and [client D] will be staff (sic) in separate rooms at the group home."</p> <p>Review of the investigation record for the 9/26/13 incident involving clients A and D indicated: "[Client A's] initial story was that [client D] raped him, however, in the course of being interviewed by his QDDP, [client A's] story changed to it being a consensual act. He then started talking about babies in his stomach and feeling things kick in his belly. [Client D] denied any contact between him and [client A] that night and staff on daily notes and sleep documentation support [client D's] story. The ER doctor completed an anal exam on [client A] who had not showered since the reported incident. He found no injury, abrasion, tears, or evidence of sexual activity. Because of inconsistency in [client A's] story, and lack of supporting evidence, it does not appear that [client A] was raped or that any contact occurred. [Client A] has a history of fabricating and of delusional talk. Earlier in the week, he had attempted to elope several times and</p>			
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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901
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	<p>his QDDP was describing the dangers of him wandering by himself. During that discussion, [client A] asked her what kinds of dangerous things could happen. She talked about rape at that time. Shortly after that discussion [client A] made the allegation. [Client A]'s guardian was satisfied with switching bedrooms to minimize contact between [client D] and [client A]. He did not wish to pursue police involvement." Further review of the record indicated the two scheduled overnight staff and clients A and D were the only persons interviewed. The record indicated:</p> <p>"Interview with [client D], consumer and QDDP and Director of Habilitation and Social Services (DHSS) on 9/27/13 at 2:30 P.M.:</p> <p>QDDP: 'How was your night? Did you sleep okay?'</p> <p>Client D: Nodded yes</p> <p>QDDP: 'The medicine keeping you awake?'</p> <p>Client D: 'Yea'</p> <p>QDDP: 'It's keeping you awake?'</p> <p>Client D: 'No'</p> <p>QDDP: 'So you slept all night?'</p> <p>Client D: 'No.' Client D pointed to his arm and said 'a tear in my arm forced me up all night.'</p> <p>QDDP: 'Do you ever get up and get you</p>			

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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901
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	<p>and [client A] a snack?' Client D: 'No, we got motivated.' QDDP: 'Did he wake you up?' Client D: 'I woke myself up.' QDDP: 'During the night, did he wake you up?' Client D: 'No. My pants and shirt got something on me.' QDDP: 'What?' Client D: 'White stuff.' QDDP: 'What do you do when you are up?' Client D: 'Normally we play the Wii (video game) and watch movies.' QDDP: 'What kind of movies do you watch?' Client D: 'Funny ones and inappropriate ones.'</p> <p>Interview with [client A] and Director 9/27/13 at 2:30 P.M. indicated:</p> <p>"Director: 'Can you tell me what happened?' Client A: '[Client D] had sex with me.' Director: 'Describe what happened.' Client A: 'He put his [penis] in my [anus].' Director: 'Did you ask him to?' Client A: 'No.' Director: 'Did you call staff to come and help you?' Client A: 'No.' Director: 'Did it last a long time?'</p>			

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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901		
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	<p>Client A: 'No. He put it in and pulled it out.'</p> <p>Director: 'One time?'</p> <p>Client A: 'Yes'</p> <p>Director: 'Then what did you do?'</p> <p>Client A: 'I tried to put my [penis] in his [anus] but it didn't work.'</p> <p>Director: 'Was this something you wanted to do and were embarrassed about, or did he hurt you?'</p> <p>Client A: 'I was feeling frisky. Now I have a baby in my stomach. I can feel it kick.'"</p> <p>A review of client A's record was conducted on 10/8/13 at 9:50 A.M.. Review of client A's record indicated: "Patient Discharge Instructions...Current Date: 9/27/13...Name: [Client A]...Follow-up Instructions: Follow up with primary care provider." Review of client A's record did not indicate he followed up with his primary care provider as recommended by the ER physician and did not indicate any testing or examinations had been conducted while at the ER. The record did not indicate the facility's nursing staff assessed client A after the incident.</p> <p>A review of the facility's "Prohibition of Violations of Individual Rights" policy no date noted was conducted on 10/7/13 at 2:17 P.M. and indicated: "In order to</p>				

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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901			
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	<p>protect the general welfare of persons served, Bona Vista Programs strictly prohibits the abuse of any form, neglect, exploitation or mistreatment of an individual or violation of an individual's rights by employees or agents delivering services on behalf of the agency.</p> <p>Definitions: Abuse: Intentional willful infliction of physical injury; unnecessary physical or chemical restraints, or isolation; punishment resulting with physical harm or pain; sexual molestation, rape, sexual misconduct, sexual coercion, and sexual exploitation...Neglect: Failure to provide supervision, training, appropriate care, food, medical care, or medical supervision to an individual...Reporting: It is the responsibility of any employee who possesses knowledge of an alleged case of neglect, battery, exploitation or violation of individual rights to report it immediately, verbally and/or in writing to the President or, if the President is unavailable, the Director, Human Resources."</p> <p>An interview with the Director was conducted on 10/8/13 at 11:10 A.M.. When asked if there was documentation to indicate the administrator was notified of the mentioned incidents, the Director stated "No." When asked if the investigation for the 5/14/13 incident had</p>						

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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901		
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	<p>been completed within 5 working days, the Director stated "No." When asked if there was documentation to indicate the facility's nursing services had completed assessments of the clients after the incidents, the Director stated "No." When asked if there was documentation to indicate all group home staff had training on bedchecks and documentation, the Director stated "No." When asked how often staff were to do and document bed checks at the group home, the Director stated "Every 30 minutes." When asked if there was documentation to indicate staff completed bed checks every 30 minutes, the Director stated "No, the documentation shows bed checks are done every hour." When asked if client A had followed up with his primary care provider as recommended by the ER physician, the Director stated "No he has not."</p> <p>This federal tag relates to complaint #IN00137327.</p> <p>9-3-2(a)</p>				

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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901
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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901		
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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 2 of 2 incidents, involving 2 of 4 sampled clients (A and B) and 2 additional clients (D and H) the facility failed to provide written evidence thorough investigations were conducted.</p> <p>Findings include:</p> <p>1. A review of the facility's Bureau of Developmental Disabilities Services reports (BDDS) and investigation records was conducted on 10/7/13 at 1:50 P.M. Review of the reports indicated:</p> <p>-BDDS report dated 5/14/13: "At approximately 2:15 A.M. on 5/14 residential staff was completing nightly rounds. She observed [client H] in the bed of [client B]. Staff described that [client B's] pants were down around his hips. [Client H] was nude and in back of [client B]. Staff stated that she saw penetration and that penetration stopped when she came in to do her nightly check. Staff directed consumers back to their beds and observed interaction until consumers fell asleep. After consumers fell asleep, nightly checks were continued every 15 minutes. [Residential QDDP</p>	W000154	<p>The agency policy related to conducting thorough investigations was updated in October 2013 and approved by the Bona Vista Board of Directors (Appendix C). All direct care staff, residential nurse, residential house manager and QDDP will be trained on the agency policy relating to conducting investigations. Investigation training policy will be trained on annually (Appendix A). Residential House Manager, QDDP, Director of Residential Services will be retrained on Bureau of Developmental Disabilities policy on Mandatory Components of an Investigation on November 26, 2013. Additional training will be provided by Steve Corya tentatively scheduled for December 10, 2013. The survey states, "an observation was conducted at the group home on 10/8/13 from 2:55 a.m. until 5:15 a.m. During the entire observation period client H's bedroom door was closed". At the time of the observation, HRC approval had not been obtained to require that the door remain open. On October 29, 2013, that approval was obtained and the door is now open during sleep hours. The survey states, "the record did not have</p>	11/26/2013	

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  10/31/2013	
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	(Quality Developmental Disabilities Professional)] and [Residential House Manager (RHM)] were contacted. [Client B] was interviewed by [Director name], [Lead QDDP], (sic) and RHM regarding the incident. [Client B] initially stated that when he went (sic) bed he was listening to music and watching videos. [Client B] stated that he does not have good memory and that the rest of the night was blurry and he only remembered bits and pieces. [Client B] stated that the only thing he remembered was what staff had already documented. When asked to describe exactly what happened, [client B] stated that he couldn't remember. [Client H] was interviewed by Director, Lead QDDP, (sic) RHM, regarding this incident. [Client H] stated that [client B] asked him to 'screw him.' [Client H] stated he went to [client B's] bed at this time, (sic) and penetration occurred. [Client H] stated no kissing or other touching occurred and penetration lasted about 20 minutes and that this has never happened before. The Director and Lead QDDP interviewed [client B] again and asked him if he had thought about the incident anymore and if he had anything else he wanted to say. This author stated to him that the main concern was his safety. He then stated that [client H] asked to touch him and [client B] refused. [Client B] then stated that [client H] came		documentation to indicate any assessments of client B by nursingservices". Per documentation (page 6 and 7 of 77 State Survey ID: Q8XJ11), Client B refused a nursing assessment but did agree to go to the Emergency room for evaluation. Nightly Check sheet has been revised to require routine monitoring every 15 minutes during sleeping hours (Appendix B). All staff will be trained in this new policy on November 26, 2013. Additionally, HRC approval was given to require bedroom doors remain open during sleep hours. The residential nurse did fail to ensure that Client A received follow up doctor appointment following emergency room visit. The residential nurse received corrective action for this oversight. Additionally, the ER follow up form was developed (Appendix D) and is required to be completed by the residential nurse following an ER visit. It documents all follow up care needed and also requires any lab work to be followed up on. It will be completed by the residential nurse within 48 hours of an ER visit and will be reviewed by the Director of Residential Services. It will be filed in the consumer chart. The survey states, "The record did not indicate the facility's nursing staff assessed client A after incident". Medical care was immediately sought for Client				

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	<p>to his bed and 'put his thing in me'. When asked why he didn't call for staff, he stated that he wanted to turn off his Ipod (radio) first...Plan to Resolve: [Client H] was taken to [Hotel name] with 2 staff for the night. [Client B] was taken to [Hospital name] for evaluation. This author contacted the police administrative number and it was answered by a voice mail. This author left a voice mail stating the situation and that [client B] was being taken to the hospital for evaluation. Staff transporting [client B] to [Hospital name] will inform hospital staff that a message regarding this allegation was left on the police administrative number voice mail."</p> <p>Review of investigation record for the 5/14/13 incident involving clients B and H indicated:</p> <p>"-5/14/13 @ (at) 2:15 A.M. residential staff was completing nightly rounds. DSP (Direct Support Professional) observed [client H] in the bed of [client B]. Staff described that [client B's] pants were down around his hips. [Client H] was nude and in back of [client B] Staff stated that she saw penetration and that penetration stopped when she came in to do her nightly check. Staff directed consumers back to their beds and observed interaction. After consumers were asleep, nightly checks were</p>		<p>A. He was taken to Community Howard Hospital for an assessment by physician. According to W318 Condition of Participation: Health Care Services,the Condition of Participation in Health Care Services is not met when individuals do not receive adequate health care monitoring and services,including appropriate and timely follow-up, based upon their individualizedneed for service". In this instance, the individualized need for services for this client appeared to be emergency roomservice rather than assessment by residential nurse. This was based on theknowledge that if sexual abuse had occurred, specific testing procedures have to followed in order to obtain evidence of abuse. Testing procedures used in these situationsare not part of the nursing assessment/service that a group home nurseprovides. To address the lack of thoroughinvestigation, the agency policy related to conducting thorough investigationswas updated in October 2013 and approved by the Bona Vista Board of Directors(Appendix C). All direct care staff,residential nurse, residential house manager and QDDP will be trained on theagency policy relating to conducting investigations. Investigation training policy will be trainedon annually (Appendix A).</p>				

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	<p>continued every 15 minutes. Residential QDDP and RHM were contacted immediately and directed DSP to monitor every 15 minutes.</p> <p>-5/14 @ 9:30 A.M. Residential Director (RD) was informed after consumers had gone to the workshop. RD instructed Lead QDDP to contact residential nurse to complete an assessment on [client B].</p> <p>-5/14 @ 4:00 P.M. [Client B] was interviewed by [Director], Lead QDDP, and (sic) RHM regarding this incident at approximately 4:00 P.M. [Client B] initially stated that when he went to bed he was listening to music and watching videos. [Client B] stated that he does not have good memory and that the rest of the night was blurry and he only remembered bits and pieces. [Client B] then stated that what he remembered was what staff already asked him and it was documented. When asked to describe exactly what happened, he stated that he couldn't remember. He refused to answer any more questions and left to go watch a movie. [Nurse] reported to [Director] that [client B] refused an assessment.</p> <p>-[Client H] was interviewed by Director Lead QDDP, (sic) RHM, (sic) regarding this incident at approximately 4:30 P.M.. [Client H] stated that [client B] asked him</p>		Residential House Manager, QDDP, Director of Residential Services will be retrained on Bureau of Developmental Disabilities policy on Mandatory Components of an Investigation on November 26, 2013. Additional training will be provided by Steve Corya tentatively scheduled for December 10, 2013.		

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	<p>to 'screw him.' [Client H] stated he went to [client B's] bed at this time, and penetration occurred. [Client H] stated no kissing or other touching occurred and that penetration lasted about 20 minutes and that this has never happened before.</p> <p>-At approximately 5:00 P.M., the Director and Lead QDDP interviewed [client B] again and asked him if he had thought about the incident anymore and if he had anything else he wanted to say. This author stated to him that the main concern was his safety. He then stated that [client H] asked to touch him and [client B] refused. [Client B] then stated [client H] came to his bed and 'put his thing in me'. When asked why he didn't call for staff, he stated that he wanted to turn off his Ipod first. [Director] asked [client B] if he would feel comfortable with an assessment by the residential nurse. He refused. When asked if he would be wiling to go to the ER (Emergency Room) for an assessment he agreed.</p> <p>-At approximately 5:30 P.M., [Director], with the help of Lead QDDP began to arrange for staffing to take [client B] to [Hospital name] for an evaluation. Staffing arrangements were also made for [client H] to be taken to [Hotel name]for the evening. While arrangements were being made, [client B] and [client H] were</p>						

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	<p>in separate areas of the house and were being monitored by staff.</p> <p>-After arrangements were made and [client B] was being transported to the ER, [Director] called the [Police Department] at (sic) alert them of the situation. This was approximately 6:30 P.M.</p> <p>-5/14/13 @ 7:30 P.M., [client H] moved with staff to hotel to separate him from [client B].</p> <p>-5/14/13 @ 7:30 P.M., [Director] contacted [Guardian] to explain the incident between [client H] and [client B]. Informed [Guardian] that [client H] was being moved from home and that [client B] was being taken to ER by [DSP] for examination. [Guardian] gave verbal approval.</p> <p>-5/14/13 @ 9:28 P.M.-[Director] contacted [Guardian] to obtain verbal approval to complete rape kit at [Hospital name]. Informed [Guardian] of information received from ER nurse that unless some injury is found, [client B] will be able to go home shortly. Informed [Guardian] that unless he heard from me again that night, to assume that [client B] was fine and going home.</p>						

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	<p>-5/14/13 ER nurse informed [Director] that no visible sign of penetration was noted and no injury present. Nothing internal was noted either. Rape kit was completed and will be sent to police. ER doctor interviewed [client B] who denied any sexual activity with [client H].</p> <p>-5/14/13 [Director] spoke to [Officer name]. [Director] informed police that both individuals have guardians and that any investigation would need to be completed via guardians. Police stated that after obtaining results of the rape kit, the case would be handed over to a detective who would contact [Director] for information on guardians (phone numbers). [Case number].</p> <p>-[Director instructed staff to complete bedchecks every 15 minutes instead of every hour.</p> <p>-5/14/13 [Director] spoke to Lead QDDP who stated she had informed [client H]'s guardian at 7:30 P.M. and would call her in the morning with an update.</p> <p>-5/14/13-10:06 P.M. [Director] called [BDDS Coordinator] and left message .</p> <p>-5/15/13-7:47 A.M. [BDDS Coordinator] called [Director] and [Director] updated him on situation. [Director] asked for</p>						

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	<p>[BDDS Coordinator]'s opinion on moving [client H] to another house. [BDDS Coordinator] was okay with that if there were no other options.</p> <p>-5/15/13-[Director] at Workshop at 8:00 A.M. to instruct staff to 1:1 (one staff with client) with [client H] until further notice.</p> <p>-5/15/13-Emergency IDT (Inter Disciplinary Team) meeting to discuss issue. Documentation from meeting saved on separate file.</p> <p>-On 5/17/13 [Director] received call from [Officer] saying there wasn't enough evidence to pursue the case. [Client B] had changed his stories and was non-committal about what happened between them. Additionally, there was no physical evidence of any penetration.</p> <p>-5/17/13-[Director] called [BDDS Coordinator] to update on police report. Reported that [client H] was still staying in a hotel.</p> <p>-[Director] asked staff at house if [client B]'s father had called him since the incident. Staff reported no.</p> <p>-5/17/13-[Director] talked to [BDDS Coordinator] about [client H] staying at</p>			

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	<p>another group home over the weekend if staff were trained. [BDDS Coordinator] gave approval. Staff was trained and documentation sent to HR (Human Resources).</p> <p>-5/21/13 at 8:50 A.M.-[Director] called [Guardian] to update him on police decision. [Guardian] has never initiated contact with [Director] up to this point to inquire about status. [Guardian] was upset that [Agency name] was considering moving [client H] back into the group home.</p> <p>-5/21/13 at 4:14 P.M. [Director] called [BDDS Coordinator] to discuss moving back [client H] back into home. [BDDS Coordinator] thought that it was appropriate as long as [client H] and [client B] weren't sharing a bedroom.</p> <p>-5/22/13-[Director] called the guardian of a consumer at [Group Home #2] to discuss possibly switching the two. She was not in agreement.</p> <p>-5/23/13-sent e mail (electronic) to IDT (saved separate file) stating plan to move [client H] back into home, to switch bedrooms and continue 15 minute bed checks. [Staff name] inquired about putting a door alarm on the bedroom but [Director] didn't feel that [client H]'s</p>						

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	<p>roommate would agree.</p> <p>-5/23/13 at 11/23/13 [BDDS Coordinator] called [Director] to tell her that he had talked to [Guardian] who stated he wanted to move [client B]. [BDDS Coordinator] explained the process to [Guardian] who became angry. [BDDS Coordinator] asked [Director] to send recent physical with diagnosis for [client B]. [Director] emailed on 5/24/13.</p> <p>-5/24/13 staff rearranged bedrooms in the home so that [client B] and [client H] were no longer sharing a bedroom. [Client H] was returned to the home (from hotel).'</p> <p>An email record dated 5/23/13 indicated: "Importance: High: Wanted to update you on the situation. I have been in regular contact with [BDDS Coordinator] regarding [client H] and [client B]. It is [BDDS Coordinator]'s opinion, that [client H] is okay to move back to [Group home name] with the following measures: he no longer share a bedroom with [client B], that staff continue nightly bedchecks every 30 minutes instead of 1 hour and that adequate staffing is present in the home. If you remember from our IDT, in order to move [client H] back to [Group Home #2], [Group home #2 client] would need to be moved and his guardian would</p>						

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	<p>need to give consent. [Group home #2 client's] guardian is NOT in agreement. Without guardian agreement, we cannot move forward with moving him. Based on that, and with [BDDS Coordinator's] input above, we are planning to move [client H] back to [Group Home name]. He will be moved into the bedroom directly across from the staff office and he will be rooming with [client E]. The measures listed above have been implemented...."</p> <p>Further review of the investigation record did not indicate all clients who resided at the group home and all staff who worked at the group home were interviewed. Review of the record did not indicate the investigation was completed in 5 working days. The record did not indicate the administrator was immediately notified of the incident. The record did not have the police report for the incident. The report did not have the lab results from the hospital.</p> <p>An observation was conducted at the group home on 10/8/13 from 2:55 A.M. until 5:15 A.M. During the entire observation period client H's bedroom door was closed.</p> <p>A review of client B's record was conducted on 10/8/13 at 9:50 A.M.. A</p>						

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	<p>review of the record indicated:                      "[Hospital name] Patient Discharge Instructions'...Current Date 5/14/13...Nursing Reason for Visit; Patient Stated Complaint: Sexual assault victim; RAPE Victim...Follow-Up Instructions: Follow up with primary care provider...Sexual Assault Exam: You have had an exam today because of a sexual assault. The purpose of this exam is to</p> <ul style="list-style-type: none"> <li>-Find out if you have any injuries that need treatment</li> <li>-Offer treatment to prevent gonorrhea and chlamydia infections (commonly transmitted diseases)</li> <li>-Offer treatment to prevent HIV infection</li> <li>-Arrange for follow up counseling</li> </ul> <p>FOLLOW UP with your doctor for continued medical care."</p> <p>The record did not have documentation to indicate any assessments of client B by nursing services. The record did not indicate any results from client B's hospital visit.</p> <p>A request for staff training documentation was made on 10/8/13 @ 11:00 A.M.. Review of the documentation submitted for review indicated: "Residential Staff Meeting" [Group home name] 6/12/13...Staff Present: [DSP #1], [DSP #2], [DSP #3], [DSP #4], [DSP #5]...Staff</p>						

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	<p>Absent: [DSP #6], [DSP #7], [DSP #8], [DSP #9], [DSP #10]...Documentation Errors-Review policy: RHM reviewing program goals daily, QDDP's reviewing daily notes 1x (one time) each week, Errors are being tracked and documented...Medication Administration Policy Reviewed: Staff signature that they understand medication admin policy...Money Policy reviewed: Staff signature on Residential money policy...Midnight cleaning checklist-cleaning is everyone's responsibility...Calling QDDP and RHM-on call procedure...Review risk plans-staff initial...1x week pop cans." Review of the record did not indicate all group home staff were trained on doing bed checks every 1/2 hour or 15 minutes.</p> <p>A review of the facility's records was conducted on 10/8/13 at 10:30 A.M. Review of the group home "Consumer Nightly Check Records" dated 5/1/13 to 10/13 indicated: "STAFF ARE TO CHECK ON EACH INDIVIDUAL EVERY HOUR AS SPECIFIED. Staff are to open each bedroom door every hour to observe consumer breathing and any device that may be used to see if it is working properly. Be sure documentation is accurate. Staff will document as they check on each consumer. If the supervising staff come in and the</p>			

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	<p>documentation is not being completed, disciplinary action will result." Review of each monthly record documentation indicated bed checks were conducted every hour. The record did not indicate bedchecks were conducted every 15 minutes or every 30 minutes.</p> <p>2. A review of the facility's Bureau of Developmental Disabilities Services reports (BDDS) and investigation records was conducted on 10/7/13 at 1:50 P.M. Review of the reports indicated:</p> <p>-BDDS report dated 9/26/13: "On Sept. 27, 2013 at 11:45 A.M. [client A] reported to his workshop supervisor [Supervisor name] that on Sept. 26, 2013 [client D] raped him. [Client A] reported that this incident happened at the group home. [Client D] was interviewed by QDDP (Qualified Developmental Disabilities Professional) and [Social Service Director]. [Client D] denied the allegations...Plan to Resolve: [Client A] and [client D] are monitored 24 hours by staff for safety. [Client A] was taken to [Hospital name] for evaluation. [Client A's] guardian has been contacted about this incident. [Client A] and [client D] will be staff (sic) in separate rooms at the group home."</p> <p>Review of the investigation record for the</p>			

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	<p>9/26/13 incident involving clients A and D indicated: "[Client A's] initial story was that [client D] raped him, however, in the course of being interviewed by his QDDP, [client A's] story changed to it being a consensual act. He then started talking about babies in his stomach and feeling things kick in his belly. [Client D] denied any contact between him and [client A] that night and staff on daily notes and sleep documentation support [client D's] story. The ER doctor completed an anal exam on [client A] who had not showered since the reported incident. He found no injury, abrasion, tears, or evidence of sexual activity. Because of inconsistency in [client A's] story, and lack of supporting evidence, it does not appear that [client A] was raped or that any contact occurred. [Client A] has a history of fabricating and of delusional talk. Earlier in the week, he had attempted to elope several times and his QDDP was describing the dangers of him wandering by himself. During that discussion, [client A] asked her what kinds of dangerous things could happen. She talked about rape at that time. Shortly after that discussion [client A] made the allegation. [Client A's] guardian was satisfied with switching bedrooms to minimize contact between [client D] and [client A]. He did not wish to pursue police involvement." Further</p>						

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	<p>review of the record indicated the two scheduled overnight staff and clients A and D were the only persons interviewed. The record indicated:</p> <p>"Interview with [client D], consumer and QDDP and Director of Habilitation and Social Services (DHSS) on 9/27/13 at 2:30 P.M.:</p> <p>QDDP: 'How was your night? Did you sleep okay?' Client D: Nodded yes QDDP: 'The medicine keeping you awake?' Client D: 'Yea' QDDP: 'It's keeping you awake?' Client D: 'No' QDDP: 'So you slept all night?' Client D: 'No.' Client D pointed to his arm and said 'a tear in my arm forced me up all night.' QDDP: 'Do you ever get up and get you and [client A] a snack?' Client D: 'No, we got motivated.' QDDP: 'Did he wake you up?' Client D: 'I woke myself up.' QDDP: 'During the night, did he wake you up?' Client D: 'No. My pants and shirt got something on me.' QDDP: 'What?' Client D: 'White stuff.' QDDP: 'What do you do when you are</p>			

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	<p>up?' Client D: 'Normally we play the Wii (video game) and watch movies.' QDDP: 'What kind of movies do you watch?' Client D: 'Funny ones and inappropriate ones.'</p> <p>Interview with [client A] and Director 9/27/13 at 2:30 P.M.. indicated:</p> <p>"Director: 'Can you tell me what happened?' Client A: '[Client D] had sex with me.' Director: 'Describe what happened.' Client A: 'He put his [penis] in my [anus].' Director: 'Did you ask him to?' Client A: 'No.' Director: 'Did you call staff to come and help you?' Client A: 'No.' Director: 'Did it last a long time?' Client A: 'No. He put it in and pulled it out.' Director: 'One time?' Client A: 'Yes' Director: 'Then what did you do?' Client A: 'I tried to put my [penis] in his [anus] but it didn't work.' Director: 'Was this something you wanted to do and were embarrassed about, or did he hurt you?' Client A: 'I was feeling frisky. Now I</p>			
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	<p>have a baby in my stomach. I can feel it kick."</p> <p>A review of client A's record was conducted on 10/8/13 at 9:50 A.M. Review of client A's record indicated: "Patient Discharge Instructions...Current Date: 9/27/13...Name: [Client A]...Follow-up Instructions: Follow up with primary care provider." Review of client A's record did not indicate he followed up with his primary care provider as recommended by the ER physician and did not indicate any testing or examinations had been conducted while at the ER. The record did not indicate the facility's nursing staff assessed client A after the incident.</p> <p>An interview with the Director was conducted on 10/8/13 at 11:10 A.M.. When asked if there was documentation to indicate the administrator was notified of the mentioned incidents, the Director stated "No." When asked if the investigation for the 5/14/13 incident had been completed within 5 working days, the Director stated "No." When asked if there was documentation to indicate the facility's nursing services had completed assessments of the clients after the incidents, the Director stated "No." When asked if all staff who worked with the clients at the group home were</p>			

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	<p>interviewed, the Director stated "No, only the staff who worked the nights of the incidents." When asked if the police report for the 5/14/13 incident was included in the investigation record, the Director stated "No it was not." When asked if the results of any examinations and testing completed at the hospital was part of the investigation record, the Director stated "No, it was not." When asked what type of inappropriate movies client D was referring to the Director stated "Pornography." When asked what the white stuff on his clothing that client D was referring to was, the Director stated "It was determined it was from dry wall from the day program." When asked if client D had the same clothes on to sleep in that he wore to the day program, the Director stated "He should not have the same clothes on."</p> <p>This federal tag relates to complaint #IN00137327.</p> <p>9-3-2(a)</p>				

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W000157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on 2 of 2 allegations of sexual abuse reviewed, the facility failed to take appropriate corrective measures and/or provide retraining in regard to allegations of sexual abuse involving clients A, B, D and H.</p> <p>Findings include:</p> <p>1. A review of the facility's Bureau of Developmental Disabilities Services reports (BDDS) and investigation records was conducted on 10/7/13 at 1:50 P.M. Review of the reports indicated:</p> <p>-BDDS report dated 5/14/13: "At approximately 2:15 A.M. on 5/14 residential staff was completing nightly rounds. She observed [client H] in the bed of [client B]. Staff described that [client B]'s pants were down around his hips. [Client H] was nude and in back of [client B]. Staff stated that she saw penetration and that penetration stopped when she came in to do her nightly check. Staff directed consumers back to their beds and observed interaction until consumers fell asleep. After consumers fell asleep, nightly checks were continued every 15 minutes. [Residential QDDP (Quality Developmental Disabilities</p>	W000157	The agency policy related to conducting thorough investigations was updated in October 2013 and approved by the Bona Vista Board of Directors (Appendix C). All direct care staff, residential nurse, residential house manager and QDDP will be trained on the agency policy relating to conducting investigations. Investigation training policy will be trained on annually (Appendix A). Residential House Manager, QDDP, Director of Residential Services will be retrained on Bureau of Developmental Disabilities policy on Mandatory Components of an Investigation on November 26, 2013. Additional training will be provided by Steve Corya tentatively scheduled for December 10, 2013. The survey states, "an observation was conducted at the group home on 10/8/13 from 2:55 a.m. until 5:15 a.m. During the entire observation period client H's bedroom door was closed". At the time of the observation, HRC approval had not been obtained to require that the door remain open. On October 29, 2013, that approval was obtained and the door is now open during sleep hours. The survey states, "the record did not have documentation to indicate	11/26/2013			

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	<p>Professional)] and [Residential House Manager (RHM)] were contacted. [Client B] was interviewed by [Director name], [Lead QDDP], (sic) and RHM regarding the incident. [Client B] initially stated that when he went (sic) bed he was listening to music and watching videos. [Client B] stated that he does not have good memory and that the rest of the night was blurry and he only remembered bits and pieces. [Client B] stated that the only thing he remembered was what staff had already documented. When asked to describe exactly what happened, [client B] stated that he couldn't remember. [Client H] was interviewed by Director, Lead QDDP, (sic) RHM, regarding this incident. [Client H] stated that [client B] asked him to 'screw him.' [Client H] stated he went to [client B]'s bed at this time, (sic) and penetration occurred. [Client H] stated no kissing or other touching occurred and penetration lasted about 20 minutes and that this has never happened before. The Director and Lead QDDP interviewed [client B] again and asked him if he had thought about the incident anymore and if he had anything else he wanted to say. This author stated to him that the main concern was his safety. He then stated that [client H] asked to touch him and [client B] refused. [Client B] then stated that [client H] came to his bed and 'put his thing in me'. When</p>		<p>any assessments of client B by nursingservices". Client B refused a nursingassessment however agreed to be seen at the Emergency Room (State Survey EventID Q8XJ11 page 6-7 of 77).Nightly Check sheet has beenrevised to require routine monitoring every 15 minutes during sleeping hours andstates clearly that all bedroom doors are to remain open (Appendix B). All staff will be trained in this new policyon November 26, 2013.</p>		

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	<p>asked why he didn't call for staff, he stated that he wanted to turn off his Ipod (radio) first...Plan to Resolve: [Client H] was taken to [Hotel name] with 2 staff for the night. [Client B] was taken to [Hospital name] for evaluation. This author contacted the police administrative number and it was answered by a voice mail. This author left a voice mail stating the situation and that [client B] was being taken to the hospital for evaluation. Staff transporting [client B] to [Hospital name] will inform hospital staff that a message regarding this allegation was left on the police administrative number voice mail."</p> <p>Review of investigation record for the 5/14/13 incident involving clients B and H indicated:</p> <p>"-5/14/13 @ (at) 2:15 A.M. residential staff was completing nightly rounds. DSP (Direct Support Professional) observed [client H] in the bed of [client B]. Staff described that [client B]'s pants were down around his hips. [Client H] was nude and in back of [client B] Staff stated that she saw penetration and that penetration stopped when she came in to do her nightly check. Staff directed consumers back to their beds and observed interaction. After consumers were asleep, nightly checks were continued every 15 minutes. Residential</p>			

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	<p>QDDP and RHM were contacted immediately and directed DSP to monitor every 15 minutes.</p> <p>-5/14/13 @ 9:30 A.M. Residential Director (RD) was informed after consumers had gone to the workshop. RD instructed Lead QDDP to contact residential nurse to complete an assessment on [client B].</p> <p>-5/14/13 @ 4:00 P.M. [Client B] was interviewed by [Director], Lead QDDP, and (sic) RHM regarding this incident at approximately 4:00 P.M. [Client B] initially stated that when he went to bed he was listening to music and watching videos. [Client B] stated that he does not have good memory and that the rest of the night was blurry and he only remembered bits and pieces. [Client B] then stated that what he remembered was what staff already asked him and it was documented. When asked to describe exactly what happened, he stated that he couldn't remember. He refused to answer any more questions and left to go watch a movie. [Nurse] reported to [Director] that [client B] refused an assessment.</p> <p>-[Client H] was interviewed by Director Lead QDDP, (sic) RHM, (sic) regarding this incident at approximately 4:30 P.M.. [Client H] stated that [client B] asked him</p>				

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	<p>to 'screw him.' [Client H] stated he went to [client B's] bed at this time, and penetration occurred. [Client H] stated no kissing or other touching occurred and that penetration lasted about 20 minutes and that this has never happened before.</p> <p>-At approximately 5:00 P.M., the Director and Lead QDDP interviewed [client B] again and asked him if he had thought about the incident anymore and if he had anything else he wanted to say. This author stated to him that the main concern was his safety. He then stated that [client H] asked to touch him and [client B] refused. [Client B] then stated [client H] came to his bed and 'put his thing in me'. When asked why he didn't call for staff, he stated that he wanted to turn off his Ipod first. [Director] asked [client B] if he would feel comfortable with an assessment by the residential nurse. He refused. When asked if he would be wiling to go to the ER (Emergency Room) for an assessment he agreed.</p> <p>-At approximately 5:30 P.M., [Director], with the help of Lead QDDP began to arrange for staffing to take [client B] to [Hospital name] for an evaluation. Staffing arrangements were also made for [client H] to be taken to [Hotel name]for the evening. While arrangements were being made, [client B] and [client H] were</p>				

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	<p>in separate areas of the house and were being monitored by staff.</p> <p>-After arrangements were made and [client B] was being transported to the ER, [Director] called the [Police Department] at (sic) alert them of the situation. This was approximately 6:30 P.M.</p> <p>-5/14/13 @ 7:30 P.M., [client H] moved with staff to hotel to separate him from [client B].</p> <p>-5/14/13 @ 7:30 P.M., [Director] contacted [Guardian] to explain the incident between [client H] and [client B]. Informed [Guardian] that [client H] was being moved from home and that [client B] was being taken to ER by [DSP] for examination. [Guardian] gave verbal approval.</p> <p>-5/14/13 @ 9:28 P.M.-[Director] contacted [Guardian] to obtain verbal approval to complete rape kit at [Hospital name]. Informed [Guardian] of information received from ER nurse that unless some injury is found, [client B] will be able to go home shortly. Informed [Guardian] that unless he heard from me again that night, to assume that [client B] was fine and going home.</p>						

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	<p>-5/14/13 ER nurse informed [Director] that no visible sign of penetration was noted and no injury present. Nothing internal was noted either. Rape kit was completed and will be sent to police. ER doctor interviewed [client B] who denied any sexual activity with [client H].</p> <p>-5/14/13 [Director] spoke to [Officer name]. [Director] informed police that both individuals have guardians and that any investigation would need to be completed via guardians. Police stated that after obtaining results of the rape kit, the case would be handed over to a detective who would contact [Director] for information on guardians (phone numbers). [Case number].</p> <p>-5/14/13 [Director] instructed staff to complete bedchecks every 15 minutes instead of every hour.</p> <p>-5/14/13 [Director] spoke to Lead QDDP who stated she had informed [client H's] guardian at 7:30 P.M. and would call her in the morning with an update.</p> <p>-5/14/13-10:06 P.M. [Director] called [BDDS Coordinator] and left message .</p> <p>-5/15/13-7:47 A.M. [BDDS Coordinator] called [Director] and [Director] updated him on situation. [Director] asked for</p>				

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	<p>[BDDS Coordinator]'s opinion on moving [client H] to another house. [BDDS Coordinator] was okay with that if there were no other options.</p> <p>-5/15/13-[Director] at Workshop at 8:00 A.M. to instruct staff to 1:1 (one staff with client) with [client H] until further notice.</p> <p>-5/15/13-Emergency IDT (Inter Disciplinary Team) meeting to discuss issue. Documentation from meeting saved on separate file.</p> <p>-On 5/17/13 [Director] received call from [Officer] saying there wasn't enough evidence to pursue the case. [Client B] had changed his stories and was non-committal about what happened between them. Additionally, there was no physical evidence of any penetration.</p> <p>-5/17/13-[Director] called [BDDS Coordinator] to update on police report. Reported that [client H] was still staying in a hotel.</p> <p>-[Director] asked staff at house if [client B's] father had called him since the incident. Staff reported no.</p> <p>-5/17/13-[Director] talked to [BDDS Coordinator] about [client H] staying at</p>			

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	<p>another group home over the weekend if staff were trained. [BDDS Coordinator] gave approval. Staff was trained and documentation sent to HR (Human Resources).</p> <p>-5/21/13 at 8:50 A.M.-[Director] called [Guardian] to update him on police decision. [Guardian] has never initiated contact with [Director] up to this point to inquire about status. [Guardian] was upset that [Agency name] was considering moving [client H] back into the group home.</p> <p>-5/21/13 at 4:14 P.M. [Director] called [BDDS Coordinator] to discuss moving back [client H] back into home. [BDDS Coordinator] thought that it was appropriate as long as [client H] and [client B] weren't sharing a bedroom.</p> <p>-5/22/13-[Director] called the guardian of a consumer at [Group Home #2] to discuss possibly switching the two. She was not in agreement.</p> <p>-5/23/13-sent e mail (electronic) to IDT (saved separate file) stating plan to move [client H] back into home, to switch bedrooms and continue 15 minute bed checks. [Staff name] inquired about putting a door alarm on the bedroom but [Director] didn't feel that [client H]'s</p>						

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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901
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	<p>roommate would agree.</p> <p>-5/23/13 at 11/23/13 [BDDS Coordinator] called [Director] to tell her that he had talked to [Guardian] who stated he wanted to move [client B]. [BDDS Coordinator] explained the process to [Guardian] who became angry. [BDDS Coordinator] asked [Director] to send recent physical with diagnosis for [client B]. [Director] emailed on 5/24/13.</p> <p>-5/24/13 staff rearranged bedrooms in the home so that [client B] and [client H] were no longer sharing a bedroom. [Client H] was returned to the home (from hotel)."</p> <p>An email record dated 5/23/13 indicated: "Importance: High: Wanted to update you on the situation. I have been in regular contact with [BDDS Coordinator] regarding [client H] and [client B]. It is [BDDS Coordinator]'s opinion, that [client H] is okay to move back to [Group home name] with the following measures: he no longer share a bedroom with [client B], that staff continue nightly bedchecks every 30 minutes instead of 1 hour and that adequate staffing is present in the home. If you remember from our IDT, in order to move [client H] back to [Group Home #2], [Group home #2 client] would need to be moved and his guardian would</p>			
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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901			
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	<p>need to give consent. [Group home #2 client]'s guardian is NOT in agreement. Without guardian agreement, we cannot move forward with moving him. Based on that, and with [BDDS Coordinator's] input above, we are planning to move [client H] back to [Group Home name]. He will be moved into the bedroom directly across from the staff office and he will be rooming with [client E]. The measures listed above have been implemented...."</p> <p>Further review of the investigation record did not indicate all clients who resided at the group home and all staff who worked at the group home were interviewed. Review of the record did not indicate the investigation was completed in 5 working days. The record did not indicate the administrator was immediately notified of the incident. The record did not have the police report for the incident. The report did not have the lab results from the hospital.</p> <p>An observation was conducted at the group home on 10/8/13 from 2:55 A.M. until 5:15 A.M. During the entire observation period client H's bedroom door was closed.</p> <p>A review of client B's record was conducted on 10/8/13 at 9:50 A.M.. A</p>						

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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901
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	<p>review of the record indicated:                      "[Hospital name] Patient Discharge Instructions'...Current Date 5/14/13...Nursing Reason for Visit; Patient Stated Complaint: Sexual assault victim; RAPE Victim...Follow-Up Instructions: Follow up with primary care provider...Sexual Assault Exam: You have had an exam today because of a sexual assault. The purpose of this exam is to</p> <ul style="list-style-type: none"> <li>-Find out if you have any injuries that need treatment</li> <li>-Offer treatment to prevent gonorrhea and chlamydia infections (commonly transmitted diseases)</li> <li>-Offer treatment to prevent HIV infection</li> <li>-Arrange for follow up counseling</li> </ul> <p>FOLLOW UP with your doctor for continued medical care."</p> <p>The record did not have documentation to indicate any assessments of client B by nursing services. The record did not indicate any results from client B's hospital visit.</p> <p>A request for staff training documentation was made on 10/8/13 @ 11:00 A.M..                      Review of the documentation submitted for review indicated: "Residential Staff Meeting" [Group home name] 6/12/13...Staff Present: [DSP #1], [DSP #2], [DSP #3], [DSP #4], [DSP #5]...Staff</p>			

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	<p>Absent: [DSP #6], [DSP #7], [DSP #8], [DSP #9], [DSP #10]...Documentation Errors-Review policy: RHM reviewing program goals daily, QDDP's reviewing daily notes 1x (one time) each week, Errors are being tracked and documented...Medication Administration Policy Reviewed: Staff signature that they understand medication admin policy...Money Policy reviewed: Staff signature on Residential money policy...Midnight cleaning checklist-cleaning is everyone's responsibility...Calling QDDP and RHM-on call procedure...Review risk plans-staff initial...1x week pop cans." Review of the record did not indicate all group home staff were trained on doing bed checks every 1/2 hour or 15 minutes.</p> <p>A review of the facility's records was conducted on 10/8/13 at 10:30 A.M.. Review of the group home "Consumer Nightly Check Records" dated 5/1/13 to 10/13 indicated: "STAFF ARE TO CHECK ON EACH INDIVIDUAL EVERY HOUR AS SPECIFIED. Staff are to open each bedroom door every hour to observe consumer breathing and any device that may be used to see if it is working properly. Be sure documentation is accurate. Staff will document as they check on each consumer. If the supervising staff come in and the</p>			

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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901
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	<p>documentation is not being completed, disciplinary action will result." Review of each monthly record documentation indicated bed checks were conducted every hour. The record did not indicate bedchecks were conducted every 15 minutes or every 30 minutes.</p> <p>2. A review of the facility's Bureau of Developmental Disabilities Services reports (BDDS) and investigation records was conducted on 10/7/13 at 1:50 P.M. Review of the reports indicated:</p> <p>-BDDS report dated 9/26/13: "On Sept. 27, 2013 at 11:45 A.M. [client A] reported to his workshop supervisor [Supervisor name] that on Sept. 26, 2013 [client D] raped him. [Client A] reported that this incident happened at the group home. [Client D] was interviewed by QDDP (Qualified Developmental Disabilities Professional) and [Social Service Director]. [Client D] denied the allegations...Plan to Resolve: [Client A] and [client D] are monitored 24 hours by staff for safety. [Client A] was taken to [Hospital name] for evaluation. [Client A's] guardian has been contacted about this incident. [Client A] and [client D] will be staff (sic) in separate rooms at the group home."</p> <p>Review of the investigation record for the</p>			

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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>9/26/13 incident involving clients A and D indicated: "[Client A's] initial story was that [client D] raped him, however, in the course of being interviewed by his QDDP, [client A's] story changed to it being a consensual act. He then started talking about babies in his stomach and feeling things kick in his belly. [Client D] denied any contact between him and [client A] that night and staff on daily notes and sleep documentation support [client D's] story. The ER doctor completed an anal exam on [client A] who had not showered since the reported incident. He found no injury, abrasion, tears, or evidence of sexual activity. Because of inconsistency in [client A's] story, and lack of supporting evidence, it does not appear that [client A] was raped or that any contact occurred. [Client A] has a history of fabricating and of delusional talk. Earlier in the week, he had attempted to elope several times and his QDDP was describing the dangers of him wandering by himself. During that discussion, [client A] asked her what kinds of dangerous things could happen. She talked about rape at that time. Shortly after that discussion [client A] made the allegation. [Client A's] guardian was satisfied with switching bedrooms to minimize contact between [client D] and [client A]. He did not wish to pursue police involvement." Further</p>						

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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901		
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	<p>review of the record indicated the two scheduled overnight staff and clients A and D were the only persons interviewed. The record indicated:</p> <p>"Interview with [client D], consumer and QDDP and Director of Habilitation and Social Services (DHSS) on 9/27/13 at 2:30 P.M.:</p> <p>QDDP: 'How was your night? Did you sleep okay?' Client D: Nodded yes QDDP: 'The medicine keeping you awake?' Client D: 'Yea' QDDP: 'It's keeping you awake?' Client D: 'No' QDDP: 'So you slept all night?' Client D: 'No.' Client D pointed to his arm and said 'a tear in my arm forced me up all night.' QDDP: 'Do you ever get up and get you and [client A] a snack?' Client D: 'No, we got motivated.' QDDP: 'Did he wake you up?' Client D: 'I woke myself up.' QDDP: 'During the night, did he wake you up?' Client D: 'No. My pants and shirt got something on me.' QDDP: 'What?' Client D: 'White stuff.' QDDP: 'What do you do when you are</p>				

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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901
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	<p>up?' Client D: 'Normally we play the Wii (video game) and watch movies.' QDDP: 'What kind of movies do you watch?' Client D: 'Funny ones and inappropriate ones.'</p> <p>Interview with [client A] and Director 9/27/13 at 2:30 P.M. indicated:</p> <p>"Director: 'Can you tell me what happened?' Client A: '[Client D] had sex with me.' Director: 'Describe what happened.' Client A: 'He put his [penis] in my [anus].' Director: 'Did you ask him to?' Client A: 'No.' Director: 'Did you call staff to come and help you?' Client A: 'No.' Director: 'Did it last a long time?' Client A: 'No. He put it in and pulled it out.' Director: 'One time?' Client A: 'Yes' Director: 'Then what did you do?' Client A: 'I tried to put my [penis] in his [anus] but it didn't work.' Director: 'Was this something you wanted to do and were embarrassed about, or did he hurt you?' Client A: 'I was feeling frisky. Now I</p>			
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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>have a baby in my stomach. I can feel it kick."</p> <p>An interview with the Director was conducted on 10/8/13 at 11:10 A.M. When asked if there was documentation to indicate all group home staff had training on bedchecks and documentation, the Director stated "No." When asked how often staff were to do and document bed checks at the group home, the Director stated "Every 30 minutes." When asked if there was documentation to indicate staff completed bed checks every 30 minutes, the Director stated "No, the documentation shows bed checks are done every hour."</p> <p>This federal tag relates to complaint #IN00137327.</p> <p>9-3-2(a)</p>				

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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901			
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W000189	<p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on record review, observation and interview, the facility failed to provide training to assure staff competence in the completion and documentation of bed checks and supervision to prevent sexual abuse. This failure had the potential to affect all clients living in the facility (clients A, B, C, D, E, F, G and H).</p> <p>Findings include:</p> <p>1. A review of the facility's Bureau of Developmental Disabilities Services reports (BDDS) and investigation records was conducted on 10/7/13 at 1:50 P.M. Review of the reports indicated:</p> <p>-BDDS report dated 5/14/13: "At approximately 2:15 A.M. on 5/14 residential staff was completing nightly rounds. She observed [client H] in the bed of [client B]. Staff described that [client B's] pants were down around his hips. [Client H] was nude and in back of [client B]. Staff stated that she saw penetration and that penetration stopped when she came in to do her nightly check. Staff directed consumers back to their</p>	W000189	To ensure that staff training istaking place as required, and to ensure that all information is being trainedon effectively, Residential House Managers and QDDP's will be required tofollow the Residential Staff Training Policy (Appendix I). This policy requiresRHM's and QDDP's to submit all agendas and training records to the Lead StaffSupervisor or the Director of Residential Services for review. Failure to submit training documentation willresult in disciplinary action. Additionally, if the Lead Staff Supervisor (or Director of ResidentialServices) determines that the training record is incomplete or does not meetthe purpose of the training for any reason, the Residential House Manager andQDDP will be required to repeat the training session. The Lead Staff Supervisor will maintain arecord of all staff trainings/monthly meetings. This policy will be trained onwith RHM's and QDDP's on November 26, 2013.Nightly Check sheet has beenrevised to require routine monitoring every 15 minutes during sleeping hoursand states clearly that all bedroom doors are	11/26/2013			

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  10/31/2013	
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			
	beds and observed interaction until consumers fell asleep. After consumers fell asleep, nightly checks were continued every 15 minutes. [Residential QDDP (Quality Developmental Disabilities Professional)] and [Residential House Manager (RHM)] were contacted. [Client B] was interviewed by [Director name], [Lead QDDP], (sic) and RHM regarding the incident. [Client B] initially stated that when he went (sic) bed he was listening to music and watching videos. [Client B] stated that he does not have good memory and that the rest of the night was blurry and he only remembered bits and pieces. [Client B] stated that the only thing he remembered was what staff had already documented. When asked to describe exactly what happened, [client B] stated that he couldn't remember. [Client H] was interviewed by Director, Lead QDDP, (sic) RHM, regarding this incident. [Client H] stated that [client B] asked him to 'screw him.' [Client H] stated he went to [client B's] bed at this time, (sic) and penetration occurred. [Client H] stated no kissing or other touching occurred and penetration lasted about 20 minutes and that this has never happened before. The Director and Lead QDDP interviewed [client B] again and asked him if he had thought about the incident anymore and if he had anything else he wanted to say. This author stated		to remain open (Appendix B). All staff will be trained in this new policy on November 26, 2013. The survey states, "the record did not have documentation to indicate any assessments of client B by nursing services". Client B refused a nursing assessment however agreed to be seen at the Emergency Room (State Survey Event ID Q8XJ11 page 6-7 of 77).				

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  10/31/2013
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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901
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	<p>to him that the main concern was his safety. He then stated that [client H] asked to touch him and [client B] refused. [Client B] then stated that [client H] came to his bed and 'put his thing in me'. When asked why he didn't call for staff, he stated that he wanted to turn off his Ipod (radio) first...Plan to Resolve: [Client H] was taken to [Hotel name] with 2 staff for the night. [Client B] was taken to [Hospital name] for evaluation. This author contacted the police administrative number and it was answered by a voice mail. This author left a voice mail stating the situation and that [client B] was being taken to the hospital for evaluation. Staff transporting [client B] to [Hospital name] will inform hospital staff that a message regarding this allegation was left on the police administrative number voice mail."</p> <p>Review of investigation record for the 5/14/13 incident involving clients B and H indicated:</p> <p>"-5/14/13 @ (at) 2:15 A.M. residential staff was completing nightly rounds. DSP (Direct Support Professional) observed [client H] in the bed of [client B]. Staff described that [client B's] pants were down around his hips. [Client H] was nude and in back of [client B] Staff stated that she saw penetration and that penetration stopped when she came in to</p>			
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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901			
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	<p>do her nightly check. Staff directed consumers back to their beds and observed interaction. After consumers were asleep, nightly checks were continued every 15 minutes. Residential QDDP and RHM were contacted immediately and directed DSP to monitor every 15 minutes.</p> <p>-5/14 @ 9:30 A.M. Residential Director (RD) was informed after consumers had gone to the workshop. RD instructed Lead QDDP to contact residential nurse to complete an assessment on [client B].</p> <p>-5/14 @ 4:00 P.M. [Client B] was interviewed by [Director], Lead QDDP, and (sic) RHM regarding this incident at approximately 4:00 P.M. [Client B] initially stated that when he went to bed he was listening to music and watching videos. [Client B] stated that he does not have good memory and that the rest of the night was blurry and he only remembered bits and pieces. [Client B] then stated that what he remembered was what staff already asked him and it was documented. When asked to describe exactly what happened, he stated that he couldn't remember. He refused to answer any more questions and left to go watch a movie. [Nurse] reported to [Director] that [client B] refused an assessment.</p>						

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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901		
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	<p>-[Client H] was interviewed by Director Lead QDDP, (sic) RHM, (sic) regarding this incident at approximately 4:30 P.M. [Client H] stated that [client B] asked him to 'screw him.' [Client H] stated he went to [client B's] bed at this time, and penetration occurred. [Client H] stated no kissing or other touching occurred and that penetration lasted about 20 minutes and that this has never happened before.</p> <p>-At approximately 5:00 P.M., the Director and Lead QDDP interviewed [client B] again and asked him if he had thought about the incident anymore and if he had anything else he wanted to say. This author stated to him that the main concern was his safety. He then stated that [client H] asked to touch him and [client B] refused. [Client B] then stated [client H] came to his bed and 'put his thing in me.' When asked why he didn't call for staff, he stated that he wanted to turn off his Ipod first. [Director] asked [client B] if he would feel comfortable with an assessment by the residential nurse. He refused. When asked if he would be willing to go to the ER (Emergency Room) for an assessment he agreed.</p> <p>-At approximately 5:30 P.M., [Director], with the help of Lead QDDP began to arrange for staffing to take [client B] to [Hospital name] for an evaluation.</p>				

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	<p>Staffing arrangements were also made for [client H] to be taken to [Hotel name] for the evening. While arrangements were being made, [client B] and [client H] were in separate areas of the house and were being monitored by staff.</p> <p>-After arrangements were made and [client B] was being transported to the ER, [Director] called the [Police Department] at (sic) alert them of the situation. This was approximately 6:30 P.M.</p> <p>-5/14/13 @ 7:30 P.M., [client H] moved with staff to hotel to separate him from [client B].</p> <p>-5/14/13 @ 7:30 P.M., [Director] contacted [Guardian] to explain the incident between [client H] and [client B]. Informed [Guardian] that [client H] was being moved from home and that [client B] was being taken to ER by [DSP] for examination. [Guardian] gave verbal approval.</p> <p>-5/14/13 @ 9:28 P.M.-[Director] contacted [Guardian] to obtain verbal approval to complete rape kit at [Hospital name]. Informed [Guardian] of information received from ER nurse that unless some injury is found, [client B] will be able to go home shortly. Informed</p>						

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	<p>[Guardian] that unless he heard from me again that night, to assume that [client B] was fine and going home.</p> <p>-5/14/13 ER nurse informed [Director] that no visible sign of penetration was noted and no injury present. Nothing internal was noted either. Rape kit was completed and will be sent to police. ER doctor interviewed [client B] who denied any sexual activity with [client H].</p> <p>-5/14/13 [Director] spoke to [Officer name]. [Director] informed police that both individuals have guardians and that any investigation would need to be completed via guardians. Police stated that after obtaining results of the rape kit, the case would be handed over to a detective who would contact [Director] for information on guardians (phone numbers). [Case number].</p> <p>-[Director] instructed staff to complete bedchecks every 15 minutes instead of every hour.</p> <p>-5/14/13 [Director] spoke to Lead QDDP who stated she had informed [client H's]guardian at 7:30 P.M. and would call her in the morning with an update.</p> <p>-5/14/13-10:06 P.M. [Director] called [BDDS Coordinator] and left message .</p>			

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	<p>-5/15/13-7:47 A.M. [BDDS Coordinator] called [Director] and [Director] updated him on situation. [Director] asked for [BDDS Coordinator]'s opinion on moving [client H] to another house. [BDDS Coordinator] was okay with that if there were no other options.</p> <p>-5/15/13-[Director] at Workshop at 8:00 A.M. to instruct staff to 1:1 (one staff with client) with [client H] until further notice.</p> <p>-5/15/13-Emergency IDT (Inter Disciplinary Team) meeting to discuss issue. Documentation from meeting saved on separate file.</p> <p>-On 5/17/13 [Director] received call from [Officer] saying there wasn't enough evidence to pursue the case. [Client B] had changed his stories and was non-committal about what happened between them. Additionally, there was no physical evidence of any penetration.</p> <p>-5/17/13-[Director] called [BDDS Coordinator] to update on police report. Reported that [client H] was still staying in a hotel.</p> <p>-[Director] asked staff at house if [client B's] father had called him since the</p>			

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	<p>incident. Staff reported no.</p> <p>-5/17/13-[Director] talked to [BDDS Coordinator] about [client H] staying at another group home over the weekend if staff were trained. [BDDS Coordinator] gave approval. Staff was trained and documentation sent to HR (Human Resources).</p> <p>-5/21/13 at 8:50 A.M.-[Director] called [Guardian] to update him on police decision. [Guardian] has never initiated contact with [Director] up to this point to inquire about status. [Guardian] was upset that [Agency name] was considering moving [client H] back into the group home.</p> <p>-5/21/13 at 4:14 P.M. [Director] called [BDDS Coordinator] to discuss moving back [client H] back into home. [BDDS Coordinator] thought that it was appropriate as long as [client H] and [client B] weren't sharing a bedroom.</p> <p>-5/22/13-[Director] called the guardian of a consumer at [Group Home #2] to discuss possibly switching the two. She was not in agreement.</p> <p>-5/23/13-sent e mail (electronic) to IDT (saved separate file) stating plan to move [client H] back into home, to switch</p>						

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	<p>bedrooms and continue 15 minute bed checks. [Staff name] inquired about putting a door alarm on the bedroom but [Director] didn't feel that [client H's] roommate would agree.</p> <p>-5/23/13 at 11/23/13 [BDDS Coordinator] called [Director] to tell her that he had talked to [Guardian] who stated he wanted to move [client B]. [BDDS Coordinator] explained the process to [Guardian] who became angry. [BDDS Coordinator] asked [Director] to send recent physical with diagnosis for [client B]. [Director] emailed on 5/24/13.</p> <p>-5/24/13 staff rearranged bedrooms in the home so that [client B] and [client H] were no longer sharing a bedroom. [Client H] was returned to the home (from hotel)."</p> <p>An email (electronic mail) record dated 5/23/13 indicated: "Importance: High: Wanted to update you on the situation. I have been in regular contact with [BDDS Coordinator] regarding [client H] and [client B]. It is [BDDS Coordinator's] opinion, that [client H] is okay to move back to [Group home name] with the following measures: he no longer share a bedroom with [client B], that staff continue nightly bedchecks every 30 minutes instead of 1 hour and that</p>						

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	<p>adequate staffing is present in the home. If you remember from our IDT, in order to move [client H] back to [Group Home #2], [Group home #2 client] would need to be moved and his guardian would need to give consent. [Group home #2 client's] guardian is NOT in agreement. Without guardian agreement, we cannot move forward with moving him. Based on that, and with [BDDS Coordinator]'s input above, we are planning to move [client H] back to [Group Home name]. He will be moved into the bedroom directly across from the staff office and he will be rooming with [client E]. The measures listed above have been implemented...."</p> <p>An observation was conducted at the group home with clients A, B, C, D, E, F, G and H on 10/8/13 from 2:55 A.M. until 5:15 A.M. During the entire observation period client H's bedroom door was closed.</p> <p>A review of client B's record was conducted on 10/8/13 at 9:50 A.M. A review of the record indicated: "[Hospital name] Patient Discharge Instructions'...Current Date 5/14/13...Nursing Reason for Visit; Patient Stated Complaint: Sexual assault victim; RAPE Victim...Follow-Up Instructions: Follow up with primary care provider...Sexual Assault Exam: You</p>						

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	<p>have had an exam today because of a sexual assault. The purpose of this exam is to</p> <ul style="list-style-type: none"> <li>-Find out if you have any injuries that need treatment</li> <li>-Offer treatment to prevent gonorrhea and chlamydia infections (commonly transmitted diseases)</li> <li>-Offer treatment to prevent HIV infection</li> <li>-Arrange for follow up counseling</li> </ul> <p>FOLLOW UP with your doctor for continued medical care."</p> <p>The record did not have documentation to indicate any assessments of client B by nursing services. The record did not indicate any results from client B's hospital visit.</p> <p>A request for staff training documentation was made on 10/8/13 @ 11:00 A.M. Review of the documentation submitted for review indicated: "Residential Staff Meeting" [Group home name] 6/12/13...Staff Present: [DSP #1], [DSP #2], [DSP #3], [DSP #4], [DSP #5]...Staff Absent: [DSP #6], [DSP #7], [DSP #8], [DSP #9], [DSP #10]...Documentation Errors-Review policy: RHM reviewing program goals daily, QDDP's reviewing daily notes 1x (one time) each week, Errors are being tracked and documented...Medication Administration Policy Reviewed: Staff signature that</p>						

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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901			
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	<p>they understand medication admin policy...Money Policy reviewed: Staff signature on Residential money policy...Midnight cleaning checklist-cleaning is everyone's responsibility...Calling QDDP and RHM-on call procedure...Review risk plans-staff initial...1x week pop cans." Review of the record did not indicate all group home staff were trained on doing bed checks every 1/2 hour or 15 minutes.</p> <p>A review of the facility's records was conducted on 10/8/13 at 10:30 A.M. Review of the group home "Consumer Nightly Check Records" dated 5/1/13 to 10/13 indicated: "STAFF ARE TO CHECK ON EACH INDIVIDUAL EVERY HOUR AS SPECIFIED. Staff are to open each bedroom door every hour to observe consumer breathing and any device that may be used to see if it is working properly. Be sure documentation is accurate. Staff will document as they check on each consumer. If the supervising staff come in and the documentation is not being completed, disciplinary action will result." Review of each monthly record documentation indicated bed checks were conducted every hour. The record did not indicate bedchecks were conducted every 15 minutes or every 30 minutes.</p>						

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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901			
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	<p>2. A review of the facility's Bureau of Developmental Disabilities Services reports (BDDS) and investigation records was conducted on 10/7/13 at 1:50 P.M. Review of the reports indicated:</p> <p>-BDDS report dated 9/26/13: "On Sept. 27, 2013 at 11:45 A.M. [client A] reported to his workshop supervisor [Supervisor name] that on Sept. 26, 2013 [client D] raped him. [Client A] reported that this incident happened at the group home. [Client D] was interviewed by QDDP (Qualified Developmental Disabilities Professional) and [Social Service Director]. [Client D] denied the allegations...Plan to Resolve: [Client A] and [client D] are monitored 24 hours by staff for safety. [Client A] was taken to [Hospital name] for evaluation. [Client A's] guardian has been contacted about this incident. [Client A] and [client D] will be staff (sic) in separate rooms at the group home."</p> <p>A request for staff training documentation was made on 10/8/13 @ 11:00 A.M. Review of the documentation submitted for review indicated: "Residential Staff Meeting" [Group home name] 6/12/13...Staff Present: [DSP #1], [DSP #2], [DSP #3], [DSP #4], [DSP #5]...Staff Absent: [DSP #6], [DSP #7], [DSP #8], [DSP #9], [DSP #10]...Documentation</p>						

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	<p>Errors-Review policy: RHM reviewing program goals daily, QDDP's reviewing daily notes 1x each week, Errors are being tracked and documented...Medication Administration Policy Reviewed: Staff signature that they understand medication admin policy...Money Policy reviewed: Staff signature on Residential money policy...Midnight cleaning checklist-cleaning is everyone's responsibility...Calling QDDP and RHM-on call procedure...Review risk plans-staff initial...1x week pop cans." Review of the record did not indicate all group home staff were trained on doing bed checks every 1/2 hour or 15 minutes. No documentation was submitted to indicate the facility provided group home staff with training on completing and documenting on bed checks.</p> <p>An interview with the Director was conducted on 10/8/13 at 11:10 A.M.. When asked how often staff were to do and document bed checks at the group home, the Director stated "Every 30 minutes." When asked if there was documentation to indicate staff completed bed checks every 30 minutes, the Director stated "No, the documentation shows bed checks are done every hour."</p> <p>This federal tag relates to complaint #IN00137327.</p>						

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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901
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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901			
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W000322	<p>483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. Based on record review and interview, the facility failed for 1 of 4 sampled clients (client A) to follow up with his primary care physician as recommended by the Emergency Room (ER) physician.</p> <p>Findings include:</p> <p>A review of client A's record was conducted on 10/8/13 at 10:00 A.M. Client A's record indicated: "Patient Discharge Instructions: Current Date 9/27/13...Patient Name: [Client A]...Nursing Reason for Visit: Patient Stated Complaint: Sexual assault victim; Sexual assault victim; Assault...Follow-up Instructions: Follow up with primary care provider." Further review did not indicate client A followed up with his primary care provider.</p> <p>An interview with the Director was conducted on 10/8/13 at 11:10 A.M. When asked if client A had followed up with his primary care physician as recommended by the ER physician, the Director stated "No he has not."</p> <p>This federal tag relates to complaint #IN00137327.</p>	W000322	The residential nurse did fail to ensure that Client A received follow up doctor appointment following emergency room visit. The residential nurse received corrective action for this oversight. Additionally, the ER follow up form was developed (Appendix D) and is required to be completed by the residential nurse following an ER visit. It documents all follow up care needed and also requires any lab work to be followed up on. It will be completed by the residential nurse within 48 hours of an ER visit and will be reviewed by the Director of Residential Services. It will be filed in the consumer chart.	11/26/2013			

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	9-3-6(a)				

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W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview, for 2 of 3 sampled clients (clients A and B), the facility's nursing services failed to meet the needs of the clients in regard to assessing clients after documented incidents.</p> <p>Findings include:</p> <p>1. A review of the facility's Bureau of Developmental Disabilities Services reports (BDDS) and investigation records was conducted on 10/7/13 at 1:50 P.M. Review of the reports indicated:</p> <p>-BDDS report dated 5/14/13: "At approximately 2:15 A.M. on 5/14 residential staff was completing nightly rounds. She observed [client H] in the bed of [client B]. Staff described that [client B's] pants were down around his hips. [Client H] was nude and in back of [client B]. Staff stated that she saw penetration and that penetration stopped when she came in to do her nightly check. Staff directed consumers back to their beds and observed interaction until consumers fell asleep. After consumers fell asleep, nightly checks were continued every 15 minutes. [Residential QDDP (Quality Developmental Disabilities</p>	W000331	<p>The survey states that "thefacility's nursing services failed to meet the needs of the clients in regardto assessing clients after documented incidents". Medical care was sought for clients A &amp; B. Client A was taken to Community Howard Hospital. According to W318 Condition ofParticipation: Health Care Services, theCondition of Participation in Health Care Services is not met when individualsdo not receive adequate health care monitoring and services, includingappropriate and timely follow-up, based upon their individualized need forservice". In this instance, theindividualized need for services for this client appeared to be emergency roomservice rather than assessment by residential nurse. This was based on theknowledge that if sexual abuse had occurred, specific testing procedures haveto be followed in order to obtain evidence of abuse. Testing procedures used in these situationsare not part of the nursing assessment/service that a group home nurseprovides.Client B, refused a nursingassessment, however consented to go to the Emergency Room for evaluation (StateSurvey Event ID Q8XJ11</p>	11/26/2013			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	Professional)] and [Residential House Manager (RHM)] were contacted. [Client B] was interviewed by [Director name], [Lead QDDP], (sic) and RHM regarding the incident. [Client B] initially stated that when he went (sic) bed he was listening to music and watching videos. [Client B] stated that he does not have good memory and that the rest of the night was blurry and he only remembered bits and pieces. [Client B] stated that the only thing he remembered was what staff had already documented. When asked to describe exactly what happened, [client B] stated that he couldn't remember. [Client H] was interviewed by Director, Lead QDDP, (sic) RHM, regarding this incident. [Client H] stated that [client B] asked him to 'screw him.' [Client H] stated he went to [client B's] bed at this time, (sic) and penetration occurred. [Client H] stated no kissing or other touching occurred and penetration lasted about 20 minutes and that this has never happened before. The Director and Lead QDDP interviewed [client B] again and asked him if he had thought about the incident anymore and if he had anything else he wanted to say. This author stated to him that the main concern was his safety. He then stated that [client H] asked to touch him and [client B] refused. [Client B] then stated that [client H] came to his bed and 'put his thing in me'. When		pages 6-7 of 77).		

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	<p>asked why he didn't call for staff, he stated that he wanted to turn off his Ipod (radio) first...Plan to Resolve: [Client H] was taken to [Hotel name] with 2 staff for the night. [Client B] was taken to [Hospital name] for evaluation. This author contacted the police administrative number and it was answered by a voice mail. This author left a voice mail stating the situation and that [client B] was being taken to the hospital for evaluation. Staff transporting [client B] to [Hospital name] will inform hospital staff that a message regarding this allegation was left on the police administrative number voice mail."</p> <p>A review of client B's record was conducted on 10/8/13 at 9:50 A.M. A review of the record did not indicate the facility's nursing staff assessed client B after the 5/14/13 incident.</p> <p>2. -BDDS report dated 9/26/13: "On Sept. 27, 2013 at 11:45 A.M. [client A] reported to his workshop supervisor [Supervisor name] that on Sept. 26, 2013 [client D] raped him. [Client A] reported that this incident happened at the group home. [Client D] was interviewed by QDDP (Qualified Developmental Disabilities Professional) and [Social Service Director]. [Client D] denied the allegations...Plan to Resolve: [Client A] and [client D] are monitored 24 hours by</p>			

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	<p>staff for safety. [Client A] was taken to [Hospital name] for evaluation. [Client A's] guardian has been contacted about this incident. [Client A] and [client D] will be staff (sic) in separate rooms at the group home."</p> <p>A review of client A's record was conducted on 10/8/13 at 9:50 A.M. Review of client A's record indicated: "Patient Discharge Instructions...Current Date: 9/27/13...Name: [Client A]...Follow-up Instructions: Follow up with primary care provider." Review of client A's record did not indicate he followed up with his primary care physician as recommended by the ER physician and did not indicate any testing or examinations had been conducted while at the ER. The record did not indicate the facility's nursing staff assessed client A after the incident.</p> <p>An interview with the Director was conducted on 10/8/13 at 11:10 A.M. The Director indicated there was no documentation to indicate the facility's nursing services had conducted assessments of clients A and B after the mentioned incidents. The Director further indicated there was no documentation to indicate client A had followed up with his primary care physician as recommended by the ER physician.</p>				

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	<p>This federal tag relates to complaint #IN00137327.</p> <p>9-3-6(a)</p>			
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